1.0
1.1
1.25
1.4
1.6
2.8
3.2
3.6
4.0
2.5
2.2
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1.0 mm
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CT

The monograph presents essential components of a
on making sequence used to incorporate formalized family
sment and service planning procedures into two existing early
vention programs in Massachusetts. The 1-year effort used a
tant to: (1) redefine screening and assessment processes to
e both child and family centered dimensions; (2) identify and
ally evaluate formalized instruments used to assess family
and strengths; (3) develop alternative individual family
e plan (IFSP) formats; and (4) develop revised intake,
ing, diagnostic, and service planning processes which reflect
ory requirements, contemporary research findings, and best
al judgement. The monograph contains six sections and
ixes. After an introduction and overview, Part II looks at the
t for family assessment and intervention including Public Law
and research findings. Methods of reviewing and analyzing
assessment instruments are presented in Part III with sections
sses of available measures and criteria for test selection.
sed in Part IV are implications of family assessment for
m organization and design. Part V considers development of an
ormat, and Part VI briefly notes training/technical assistance
ations. Seven appendices provide information on measures of
support and family behavior, significant life stressor scales,
ality of caregiving environment scales. Contains a list of over

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INCORPORATING FAMILY ASSESSMENT AND INDIVIDUALIZED FAMILY SERVICE PLANS INTO EARLY INTERVENTION PROGRAMS: A DEVELOPMENTAL, DECISION MAKING PROCESS

Thomas T. Kochanek

Donna Haig Friedman

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Thomas T. Kochanek

INCORPORATING FAMILY ASSESSMENT AND INDIVIDUALIZED FAMILY SERVICE PLANS INTO EARLY INTERVENTION PROGRAMS: A DEVELOPMENTAL, DECISION MAKING PROCESS

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Concern and interest for young children and their families have
aralleled levels of prominence within the past two years. This a
ention to the early childhood period originates from multiple sou
earch advances in the field of infant behavior have resulted in i
erstanding of the learning capacities of newborns, the role of pe
x in compromising growth and development, and the enormous impact
eriences on the psychologic development of the infant. Until rec
y parents were led to believe that their infants could not taste
e incapable of sensing odors, and experienced marginal feeling of
dies have indicated that, in fact, neonates are excellent discrim
taste, and can detect their own mother's fragrance by four days o
ositt, 1986).

Dramatic changes are also evident in the prevalence of families
ch a parent assumes child care responsibilities on a full time ba
cisely, while approximately 34% of all mothers of children less t
rs of age were engaged in positions outside of the home in 1975,
nding figure for 1986 is 51%. Similar increases are noted for mo
ldren three to five years of age as well, and projections indicat
roximately 70-80% of mothers of preschool children will become me
work force in the next decade (U.S. Department of Labor, 1987).
nds have prompted several lines of interesting and controversial
uiry (Belsky, 1985; Belsky and Steinberg, 1979) which though inco
e added impetus to the overall concern.

Mass publications have also contributed to the visibility of th

ticulating a "vision" which regards and strengthens commitments t
d families is no longer considered unique but rather essential.

Central to the escalation in interest in young children has be
gnificant acknowledgement of special needs infants, toddlers, and
milies. This attention has both empirical as well as legislative
ngs. Numerous studies published within the last decade have iden
ort term as well as persevering benefits of early intervention se
errueter-Clement, 1984; Garland, 1981; McNulty, 1983; Schweinhart
ile there remain several instrumentation, methodological, and sam
exities, nevertheless, the prevailing mentality is that early int
ograms constitute a powerful habilitative and preventative force.

So persuasive has the body of literature become that the re-au
the Education of the Handicapped Act in 1986 (P.L. 99-457; Part
ovisions for states to launch major program development initiativ
itten by the Federal Government, such that by 1991, a comprehensi
rly intervention system would result. While this legislation gra
nsiderable latitude in conceptualizing and articulating a system,
escribe fourteen essential components which must be represented i
atewide plan, including such issues as a definition of the popula
rved, continuum of child and family services, intra and interagen
nagement processes, comprehensive system of personnel development
rveillance procedures.

A stipulation in the legislation which perhaps has prompted gr
tention relates to conducting family assessments and developing i
ized family service plans (IFSPs) for each child and family serve

he manner in which those needs will be met

complexity of this process, and also of th

which meaningful policy could be crafted,

hich serves as the lead administrative age

vices in Massachusetts, collaborated with

, Thomas T. Kochanek, Ph.D., in order to e

field trial experience which would systema

e following representative family assessme

ns.

mily traits and/or circumstances are most

r service and furthermore, are powerful pr

n children subsequent to school entry?

andardized measures exist to assess these

tances?

he adoption of these measures in select EI

n and families would be deemed eligible fo

he children and families identified, what

iate and responsive to their needs? Do th

nsion of the existing EI continuum of serv

he identified needs and service required,

meetings with the consultant in order to; (1) re-define screening ment processes which include both child and family centered dimens (2) identify and critically evaluate formalized instruments used t family needs and strengths; (3) develop alternative IFSP formats w congruous with definitions and select instruments; and (4) develop intake, screening, diagnostic, and service planning processes whic statutory requirements, contemporary research findings, and best c judgement. Each program has, in fact, generated a data collection process which was initiated in February, 1988.

The primary purpose of this monograph is to convey the essent components of a decision making sequence used to incorporate forma family assessment and service planning procedures into existing EI It is critical to note that the intent of this document is <u>not</u> to recommend adoption of a specific approach, but rather to convey th sequential activities and decisions which are critical to the deve responsible practices. As such, the organization and content of t reflects both information and a series of questions which should a guiding programs through this decision making framework.

It is also important to note that incorporating family assessm service planning activities into EI programs is not an isolated act rather a process which prompts complex questions regarding the int design of early intervention services. For example, evaluating fa ment measures cannot occur independent of legitimate queries which existing eligibility criteria and the manner in which services are

egarding the primary mission of ear
nd its range of appropriate service

Finally, the feasibility of inc
eviewed extends far beyond the capa
ative, representative instruments a
hich will hopefully eventuate in ef
ecommended practices.

rly intervention, its target po

es.

cluding sample protocols of all

ability of this document. As a

and complete references are inc

fficient and economic implement

storical Overview of Services to Families in Early
tervention

n reviewing the roles which families assumed in early in
ms within the last decade, it becomes apparent that whil
ily involvement was acknowledged, this participation typ
he adjunctive role of parents in the development and edu
en (Guralnick and Bennett, 1987). In certain instances,
instructional responsibilities, with the content and dir
determined primarily by various professionals. In other
xpected to "generalize" the center based program into th
rce skills which were a core ingredient in the intervent
s were also provided with information on community servi
p format. These services were provided with minimal var
l and Gallagher (1982) to comment that "it is not unusua
ms for high risk or handicapped infants that have highly
ms for each infant, but only a single package for involv
9).

he etiology of this preoccupation with child competence
ge part, to the language and expectations of P.L. 94-142
crafted for school age children. Inherent within the in
t was an emphasis upon assessment of learning and behavi

Ackn

s monograph was supported, in pa
ds awarded to the Massachusetts
tribution of all staff and famil
ervention Program of the Douglas
gram of the South Shore Mental H
ed. Furthermore, sincere gratit
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gram development initiative.

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ham, and Andrea Weiss of the Dep
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append select family assessment
nard, Marie M. Bristol, Betty M.
ubbin.

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ect and the preparation of this documen

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measures to this monograph: Kathryn E
Caldwell, Carl J. Dunst, and Hamilton

lege.

t even minimally acceptable psychometric standards, and more
designed (theoretically and clinically) to identify the
is of dysfunctional family interactions. This information has
in developing child centered objectives and furthermore, most
ot assume the psychotherapeutic identity which is embodied in
ales.

e majority of university based training programs, irrespective
ipline (e.g., education, physical therapy, speech and language
asize the acquisition of competencies which pertain only to
tervening with children, not their primary caregivers. As
ientially and attitudinally, clinicians manifest a child
h to the exclusion of examining family needs, resources,
d support systems.

(Part H.) Stipulations

d earlier, the Education of the Handicapped Act amendments
tes to "develop and implement a comprehensive, coordinated
y, interagency program of early intervention services for
nts, toddlers, and <u>their</u> <u>families</u>." States are afforded a two
riod during which time policies are to be developed that ensure
f the function of each handicapped infant and toddler <u>and</u> <u>the</u>

tement of the family's strengths and needs relating to enhar
evelopment of the family's handicapped infant or toddler.

tement of the major outcomes expected to be achieved for th
t and toddler and the family, and the criteria, procedures,
ines used to determine the degree to which progress toward
ving the outcomes are being made and whether modifications
ions of the outcomes or services are necessary.

tement of specific early intervention services necessary to
nique needs of the infant or toddler and the family, includ
requency, intensity, and the method of delivering services.

rojected dates for initiation of services and the anticipat
ion of such services.

ame of the case manager from the profession most immediatel
ant to identified needs of the child and family who will be
nsible for the implementation of the plan and coordination
agencies and persons.

teps to be taken supporting the transition of the handicapp

sing single predictor variables such as anoxia (Corah et al.,
(Wiener, 1962), and neurological status (Parmelee and
ave shown little or no correlation with subsequent measures

that have examined isolated factors as well as the
tiple indices report results only marginally more encour-
insworth and Hainsworth, 1972; Levine et al., 1977).
and Parmelee (1979) found that even using a wide range of
g., obstetrical complications, newborn neurological exami-
ention, Gesell Developmental Scales), the categorization of
he risk score system had limited predictive value with
easurement of mental, motor, and language indices. In short,
opmental predictions based upon constitutional factors alone
urate.
apparent therefore, is that a child's development cannot be
ent of caretaking experiences. Powerful cross-cultural
et al. (1985) underscore the impact of social environment
nce in that epidemiologic surveys in Sweden have discovered
severe developmental disabilities to be approximately .3%,
s observed in the United States. Conversely, the prevalence
ardation in Sweden is about .4%, ten times lower than rates
ited States.
s which have compared the predictive power of child centered
ogical factors (Bee et al., 1982; Mitchell et al., 1985;
suggested that: (1) isolated measures of child performance,

investigations (Kochanek et al., 1987; Broman et al., 1985; Nichols 1981) have also identified the critical role of ecological factors, fically maternal education, as a statistical determinant of learning ioral, and cognitive deficiencies. Fortunately, recent studies have d such static indicators (e.g., level of educational attainment) and to articulate the processes and maternal behaviors which relate to quent child competence (Dunst et al., 1987; Barnard and Bee, 1985; ell et al., 1985).

Finally, Sameroff et al. (1987) has offered additional insight into ple risk models by examining the impact of ten factors on verbal IQ ed at four years of age. Specific risk factors included such condit ternal anxiety and mental health, stressful life events, family soci rt, occupation and education levels, and mother/child interactive iors. Results indicated that as the number of risk factors increase lectual performance decreased, with the difference between the lowes st groups being approximately 30 IQ points. Of greatest interest is ild centered information was entered into the multiple risk analyses wo groups noted above differed by about two standard deviations.

Significant implications of the above data are as follows.

1. Early detection and intervention efforts must broaden in definit and scope. The degree of risk or the severity of potential deve mental disability for infants cannot be accurately predicted by

ppointing results. In fact, evidence suggests that sele
ldren for programs based upon isolated factors (e.g., SES
ssurance that those most in need will be served.

ening models must include sources of data beyond that pr
hild alone. Longitudinal studies report complex intera
en a child's physical, neurological, and developmental
nvironmental context within which a child is reared (We
., 1971). Assessing newborn and early developmental st
alent importance to caregiver response and adaptation t
oping child.

illance programs should be serial in their operation.
nstability of findings reported in several studies (Lev
1977), screening outcomes should not be simply binary i
, refer for diagnostic testing; exit from system), but
ct an ongoing process with the frequency and content of
determined by the type and extensiveness of special nee
gh multi-factorial screening data.

research findings from predictive validity studies may
narized as follows.

ning/assessment models must include sources of data beyo
tence measures and/or traumatic prenatal and neonatal ev

ransactions.

m Efficacy Studies

o the extreme variability which exists within and among e
on programs, it is extraordinarily difficult to advance u
concerning the effectiveness of EI services (Simeonsson
r example, the definitions of handicapped and high risk p
ambiguous, and do not adequately account for severity dim
ce of additional, secondary disabling conditions. Second
ck adequate detail regarding the precise nature of the tr
nd therefore, definitive findings about what works for wh
conditions, continues to elude specificity. Yet another
nodologically relates to inadequate attention devoted to
of proper comparison groups as well as random assignment
f the most significant limitations of efficacy studies co
preoccupation with child level of functioning (Shonkoff a
). While parental lack of knowledge or cognitively and e
ed parent/child interactional patterns have been the targ
interventions of EI programs, the effects of these treat
ystematically examined. Despite this empirical void, imp

While the threats to internal validity (Campbell and Stanley, 1966) no
cannot be minimized, it is important and also possible to attempt to
ify efficacious program elements which are robust across studies, and
ize isolated bits of evidence which, when viewed as a gestalt, assist
fying significant findings and charting a meaningful course of future
y. To this end, what follows is a very brief overview of efficacy
ture pertaining to environmental, biological, and established risk
en with particular emphasis upon areas of family functioning which ha
ssociated with enhanced child outcomes, and thus are worthy of attent
nceptualizing family assessment processes.

Programs for Environmentally At Risk Children

he majority of programs in this cluster of studies have served childr
ocially, educationally, and economically disadvantaged families. Mos
ildren who participated in these programs represented minority popula
residing within urban areas. Programs typically began at infancy and
ed through the preschool period.

ith respect to child outcome, of the nine studies (Bryant and Ramey,
which reported serial IQ scores, six revealed statistically significa
ences between experimental and comparison groups. Of greater importa
fact that infancy intervention projects support an intensity hypothe
s, home visits alone did not substantially alter intellectual develop
two. However, home visits in addition to medical and educational

s and reported three principal findings: (1) program recipient
ly to be retained or referred for special education services; (
al group children were more achievement oriented; and (3) enrol
higher educational and occupational aspirations for their child
rol families. Similar findings were reported by Schweinhart an
0) who indicated that program graduates were employed more ofte
er incomes, and made less use of public assistance programs tha
arison groups.

In summary, data appear to suggest that children from socially
dvantaged families benefit intellectually from sustained and co
rations of the caregiving environment. Data also appear to sup
sactional hypothesis in that infant intellectual behavior can b
the acquisition and application of specific competencies by pr
givers. As such, cognitive development can be potentially infl
ematic efforts aimed at the dyadic interactional system of infa
caregivers.

Programs for Biologically At Risk Children

While the low birthweight neonatal intensive care unit (NICU)
ost prevalent constituency in this cohort, other common at ris
de perinatal asphyxia, central nervous system infection and/or
ined hypoxia. Clearly, the concept of elevated risk must be v
ly since, for the majority of biologic insults, most infants w
est the developmental complications for which they have increa

ing such dyadic interactional patterns have multiple
lly including a component of infant "readiness" for
ion on parent instruction in initiating and maintai
ue with the newborn.

comprehensive review of 17 neonatal developmental
tt, 1987), which included primarily interventions o
alization, revealed equivocal findings. Examining
included developmental, medical, and parental outco
t that positive effects are generally short term, w
omental differences rarely reported at one year of
biological compromises described earlier have adverse
gs, the accumulated evidence does not yield a verif
ecommendations. At the clinical level however, it
ns which attempt to facilitate effective parenting
orate extended home visitation and follow up compon
hood of achieving meaningful results. Moreover, in
upon teaching parents methods of caregiving, and al
attitudes, and behaviors appear to promote develop
reinforce and elicit behaviors necessary for fost
oment (Field, 1982).

Programs for Established Risk Childre

encies.

or children with Down Syndrome, studies have repeate
es over time in cognitive performance can be signifi
ly eliminated during the period in which early inter
ed (Hanson and Schwarz, 1978, Kysela et al., 1981; R
While an inadequate number of followup studies hav
elative to the perseverance of this positive effect,
ntable that programs can stabilize development in Do
ddlers, and provide a model to ensure continuous pro
n, regardless of their entry level abilities.

th respect to the etiologically heterogeneous group
n with verifiable biological bases, a series of 14
cker, 1987) reveal inconsistent findings. While th
to be more adversely affected by the methodological
, nevertheless, data suggest only modest gains in ge
ment, with virtually little or no attention devoted
s.

erall, evidence suggests that the decline in intelli
ing age which has been observed with Down Syndrome c

aring of special needs children. In brief, Dunst et al. (1
ocial support has direct and indirect influences on parent
integrity, parent/child interactions, and child behavior a
Dependent measures in these studies have included parental
eing, family integrity and adaptations, parental styles of
ild developmental competence. Studies have indicated (Duns
hat social support not only accounts for a significant amo
the dependent measures, but also proves to be the most si
ng variable, even when compared to parent and child charac
(i.e., professional) sources of support.

dditional studies exist (Trivette and Dunst, 1986) which pr
tiation that health and well-being, time demands placed up
child, family integration, and parent perceptions of child
n part, affected by the helpfulness of a family's informal
network. Overall, these and other studies (Cohen and Sym
1983) have found that support plays a significant role in
family, and child functioning, and adds to a growing body
uggests a family systems perspective to assessment and int
nally, in a meta-analytic evaluation of 31 studies which e
of EI services on handicapped children, Shonkoff and Haus
d that not only were services effective in prompting child
s, but also that the most successful programs included tho
d intervention at parent/infant dyads as well as revealed

1. Programs for special needs children in which planned, ex
parental involvement occurs show significantly greater e
programs with little or no parental participation.

2. Programs for special needs children which target their e
parents and children together appear to be more successf
programs which work with either parents or children in i

3. Intervention projects for environmentally at risk infant
support an intensity hypothesis and also indicate that d
family intervention seem to account for the most signifi
cognitive abilities.

4. Studies have found that social support plays a significa
affecting parent, family, and child functioning, and can
effects of both infancy risk and stressful life events.

asses of Available Measures

onsistent with predictive validity and program ef
ted, four areas of family functioning appear to h
pact; these respective areas include:

Family Needs, Resources, and Strengths

Social Support Network

Significant Life Stressors

Characteristics of the Caregiving Environment

t is critical to note that a wide array of standa
ments exist which are not reflected in the above
se measures present adequate psychometric charact
n numerous research applications, their utility w
s untested. For example, the Family Environment
is a measure of social climate which focuses upon
ersonal relationships among family members, direct
ized in the family, and on the basic organization
. Similarly, the Family Assessment Device (Epste
is an instrument designed on the premise that ind
luated independent of the family unit and in fact,
es from family dysfunction. The common denominat

It is also important to reiterate that the intent of this mo
o recommend adoption of specific measures, but rather to convey
nd a process through which programs can reach thoughtful decisio
amily assessment and IFSP processes. To this end, complete refe
ents (Dunst and Trivette, 1985; Dunst et al., 1987; Olson et al.
e consulted, however to facilitate the review process, a matrix
ocial support and family behavior (Dunst and Trivette, 1985) is
ppendix A. in addition to reliability and validity data in Appen
ust be emphasized that this is not intended to serve as an end p
ather a stimulus for a comprehensive search and analysis.

What follows is a brief overview of the skills and factors r
ithin each of the above domains as well as select, representativ
ithin each area.

. Family Needs, Resources, and Strengths

Bronfenbrenner (1975) has convincingly argued that while "in
rograms must place major emphasis on involving the parent direct
ctivities fostering the child's development, many families live
ppressive circumstances that they are neither willing or able to
nadequate health care, poor housing, lack of education, low inco
ecessity for full time work rob parents of time and energy to sp
hildren (pp. 465-466). As a result, the goal of family assessme

y professionals, as the focus of interventi
iculation of family needs, primary emphasis
ly's formal and informal social support net
ese needs will be met. Accordingly, a uniq
n which professionals fulfill their respons
ender less direct intervention around needs
ays in which needs can be met independently
of this perspective requires a re-analysis
their help-giving responsibilities and beh
the four operational components include: f
strengths and capabilities, social support
The help giving behaviors employed by prof
and empower" families to use and/or develop
s for meeting needs. Needs may be identifi
hniques or needs-based assessment scales, h
ss highly regards the family's perspective
directions.

discussion and further elaboration of expressed needs as well
ways in which needs can be resolved.

ily Needs (Bailey and Simeonsson, 1985)

f Family Needs is a checklist completed by parents which
cit information regarding essential needs including finances,
information regarding community based services, and overall
ing and methods of conflict resolution. Major features of this
include its ease of completion, and items which are functional
based applicability. In addition, the items provide useful
kly identifying unmet needs, and in providing opportunities for
orate on these needs and the ways in which assistance has been
provided.

entory (Zeitlin, 1985)

Inventory is based upon a transactional model which postulates
h stress is a four step process: determination of meaning,
, coping efforts, and evaluation of outcome. Within this
ess, data are collected which identify the concerns, stressors,
s, and vulnerabilities of the family. Information is collected
port instruments, structured interviews, checklists, and
actions. The model presumes that intervention services need to

antially influence familia
tal styles of interaction
eck et al., 1986), and chi
. Different forms and typ
ified needs, promotes posi
influence child competence
From an operational point
mal sources (e.g., friends
ls and agencies). Of enor
informal support from pers
ring influences, and that
er from that attributable
The attributes of social s
density, connectedness, f
or satisfaction with suppo
sions within the family as
tured opportunity to ident
y, to precisely portray th

al well being (Patterson and McCub
(Trivette and Dunst, 1987), child
ld behavior and development (Crni
es of support, particularly that
tive caregiver interactional styl
.

of view, support can be different
, relatives) vs. formal sources (
mous interest is that research has
onal network members has powerful
the effects of informal support a
to formal support.

upport which are typically assesse
requency of contact, and the perce
rt provided. The inclusion of soc
sessment process is useful in that
ify not only social isolation but
e existence and strength of connec

d to successful adaptation for famili

(Dunst, Trivette, and Jenkins, 1987)
ort Scale (FSS) measures the extent t
xist and are helpful to families rear
8 items which identify the availabili
al support and if available, their pe
linically relevant data derived from
s are evident: total number of avail
of helpfulness.

Support (Trivette and Dunst, 1987)
f Social Support provides an alternat
of assistance provided by various in
espondent reports not only "frequency

, but is somewhat less

ist a maximum of ten ne

questions on the ISS) a

rt network could provid

e scale exist; the firs

nd allows the responden

Resembling the format

ual portrayal of a resp

uency of contact) and q

useful in establishing

t Life Stressors

structured in that the respon

eds or projects (as compared

nd furthermore, to indicate w

e assistance for each express

t includes preselected groups

t to insert specific members

of the ISS, the Personal Netw

ondent's support system, and

ualitative (dependability) in

need/support system relation

e raised regarding the utility of these data to craft
on must certainly be exercised in using such instrumen
rmation which greatly assists in understanding current
.

entative instruments in this domain, included in Appen

ntory of Life Events and Changes (McCubbin, Patterson,
1982)

mily Inventory of Life Events and Changes (FILE) is a
ntory which is designed to measure the normative and n
h a family has experienced. As a family change invent
untered by family members are recorded since, from a f
, experiences to one member affect all family members.
ealing with several stressors concurrently, and as suc
ndex of cumulative risk. Conceptual dimensions measur
include: parenting and marital strains, pregnancy and
nances, and family and work transitions. A total sum
s used for scoring; higher scores imply lower stress.

ence Survey (Sarason, Johnson, and Siegal, 1978)

fe Experiences Survey is a list of events which may ha

Characteristics of the Caregiving Environment

A final component to a comprehensive family assessment proc
appraisal of the overall home environment. Within this domai
eractional patterns are important, however, it has been repor
eractions are significantly affected by the context within wh
ber, 1988). Therefore, this assessment must include parental
cs and behaviors, organization of the physical environment, a
nt/child engagement and responsiveness. It is also important
be interpreted within the family cultural and ethnic contex

Perhaps the greatest concern in this area is that inferenti
mes a significant role in the assessment process, and given
vidual biases and beliefs, family interactional patterns can
ed. In addition, while a great deal of attention has been de
dentifying atypical interactions, little effort has been dire
ning those behaviors which, without variation, facilitate wel
lopmental competence. In the absence of this empirical conse
ndividual interpretation becomes very dominant, and moreover,
ntial conflict between professionals and caregivers. Represe
ruments, included within Appendix F., are as follows.

Observation for Measurement of the Environment (Bradley and
1984)

h a combination of observation and interview of the chil
ver, completed in the home with the child present and aw
ndicated that HOME scores are significantly correlated w
e and as such, this instrument includes parent behaviors
traits which are presumed to assume a major role in a c
omental pathway.

g Child Assessment Feeding Scale (Barnard, 1978)

he Nursing Child Assessment Feeding Scale (NCAFS) was de
be the repertoire of infant and maternal behaviors broug
ctional process of feeding. The NCAFS, for use with chi
year of age, is comprised of 76 items organized into si
ch describe the adult's behavior, and two of which descr
or. They include: parent's sensitivity to cues, parent
s distress, social-emotional growth fostering, cognitive
hild's clarity of cues, and child's responsiveness to pa
g Scale permits a structured, clinical view of a process
ar and well rehearsed for both members of the dyad.

g Child Assessment Teaching Scale (Barnard, 1978)

he Nursing Child Assessment Teaching Scale (NCATS), desig
rth to three years of age, includes 73 items which are
subscales noted above for the NCAFS. The teaching scal
be a mother teaching her infant a specific sensori-motor

ia for Test Selection: Level 1

nceptualizing a decision making process which atte
arch findings and implications, and also includes
tive measures and the implications of their adopti
developmental process is recommended. At the fir
s which must be addressed include the functional u
ment decisions, IFSP development) of select measur
hey are integrated into ongoing program operations
praisal of the technical adequacy of specific inst
his level.

econd stage of review and development occurs at th
by a group of interdisciplinary staff and parents.
this process is to critically analyze family asses
relative to actual service delivery. As such, fo
y and intrusiveness of select measures, examining
asures and overall program organization, capabilit
ffort factors. Specific areas to be addressed wit
his process are as follows.

es.

other detailed manuscripts exist relative to col
ta for either decision function (Meisels and Wa
utility of family focused measures in making rel
nd eligibility judgements remains, for the most
, important questions to be addressed are as fol

at is the relationship between the type of child
sessment data collected (i.e., quantitative, qua
d the methodology of team decision making? If t
inary team has adopted a style which substantive
inical observation and inference, then measures
formation (e.g., structured interviews, open end
ompts) may be most useful.

at is the relationship between the screening/ass
llected and definition of the population to be s
sed, non-specific definitions of the eligible po
asures which yield quantitative results may be u
nversely, if eligibility criteria are developed
accommodate only seriously involved children an
en family centered dimensions may need to yield
ich assist in identifying a small segment of the

hat the primary goal of the screening process is to
hildren from birth to three with developmental anom
ulnerable, low resource families within which child
ubstantial risk for subsequent school failure. The
imited resources is not restricted to tangible area
ousing, medical care, nutrition), but also includes
aregiver characteristics such as parenting skills,
ompetence, ability to access and appropriately util
ervices, alternative modes of dealing with adversit
ntrafamilial and extrafamilial support systems, and
ntrapersonal competence.

hat in order to minimize decision making error, the
hould be a two-tiered model which reflects differen
pecificity at each level. To the maximum extent pos
creening model should be incorporated into all exis
ervices (e.g., Maternal and Child Health neonatal s
reventive Pediatric Services). Moreover, the basis
egarding need for additional diagnostic testing sha
ccording to three sources of information: (a) chil
b) parental traits, and (c) maternal/child interact

Program Evaluation

The major issue to be addressed in this area is the ex
lected are useful in examining change in family members,
ctioning over time. Significant issues are as follows.

1. To what extent are the measures sensitive to the d
family needs, crises, and resources? Do the organ
of the measure permit and encourage ongoing assess
merely annual review?

2. Does periodic assessment yield data which examine
stated objectives? In those instances of minimal
measure suggest barriers or impediments which requ

3. Do the measures include criteria against which pro
family objectives may be determined? Does this fo
parent and professional appraisal?

Technical Adequacy

he instrument review process.

xtent do the family centered meas
developing statements of current
rt systems?

xtent do results facilitate prior
of objectives or plans which coin

xtent do results assist in portra
dentified needs, existing resourc
ty between the two?

xtent do results assist in develo
sibility between professionals an
jectives?

xtent do results assist in specif

consistency of scores obtai
e instrument or with equival
purposes: (1) to estimate t
error; (2) to estimate an in
e standard error of measure-
include the method used to c
test-retest interval, and v
ata are collected. Reliabil
ce of reliability) to 1.00 (
of .80 is viewed as a minima
y refers to the extent to wh
measure. Four categories of

tent validity indicates whet
resentative sample of the be

dictive validity involves te
inst future performance in t
t.

current validity is determi

ned when successive measures are ta
ent measures. Reliability coeffici
he instrument's relative freedom fr
dividual's true score; and (3) to
ment. Factors which affect test
alculate the reliability coefficien
ariation within the environment wit
ity coefficients may range from .00
perfect reliability); generally, a
lly acceptable standard.
ich an instrument measures what it
validity are important.

her the test covers a sufficiently
havioral domain under consideration

sting the effectiveness of a measur
he areas allegedly measured by the

ed by comparing test performance an

s in which parents and staff will subsequently work together
dual Family Service Plans. As early as possible in the
erefore, both team professionals and parents should be
laboration can provide information regarding the hurdles
ill need to attend to, identify specific training and
e needs, and reveal expectations and concerns of both staff
ng the process.

he diversity of families served within a program provides a
presentation. Relevant factors include cultural/ethnic
s as well as mothers, and representative family coping
and ideologies (Chandler et al., 1986). Significant
ecision making process which parents need to address include
of specific instruments and methods relative to vocabulary,
bility to family priorities and cultural norms, and
ily expectations regarding the goals of early intervention.
provide an equally important perspective derived from their
ound, academic training, and from the diversity of families
been engaged. They contribute significantly to the deci-
by addressing such issues as the relationship between
nd the primary concerns of families, clinical and face
tools, relevance of instruments to families of divergent
nic backgrounds, differential utility of select measures
children are at biological, established and/or environ-
ecific training needs inherent within such new assessment

The adoption of specific family assessment measures permits programs
llect new information on existing families and in addition, may allow n
ilies to be judged as eligible for EI services. Consequently, program
efully and thoughtfully assess their ability and interest in not only
responsibility, in conjunction with the family, for newly identified
g., housing, transportation, child care), but also in perhaps serving
families who present with needs that the program is inadequately equ
handle or philosophically feels that other providers are perhaps more
ropriate intervenors.

The selection of assessment measures must be integrally related to t
racteristics of the families served by a program. Achieving the best
ween tools, methods of assessment, and families served is of primary i
ce in the planning and decision making process. For example, cultural
affect a family's willingness to complete various assessment tools.
ortant considerations with respect to specific ethnic groups served ar
ows.

Is it acceptable for "outsiders" to be involved in family business?

What constitutes a concern legitimate enough for "outsider" involvem
and what are the accompanying feelings for family members (e.g.,
embarrassment, anger)?

Who is the gatekeeper within the family through whom all outsiders m

able and valid results. Will assessme
into other languages for optimal result

is unique in structure, strengths, and
o these and other questions related to
am in instrument selection. Parents re
a program can be the most helpful guid
cant factors to be considered include
cultural definitions of normality and
rs, and normative avenues for social su
ick et al., 1982). Staff members nativ
ogram can also provide insight. Educat
comes an important consideration in se
larly with respect to looking at the co
vocabulary, concepts, format). The anx
are not confident about their reading a
d must be handled in a sensitive manner
of instruments will substantively affe

developing self-sufficiency in meeting their ow
needs for shelter, clothing, food, and transport
eting an educational program. The priorities wh
must be identified within a family assessment p
ul for adolescent parents in early intervention.
ust also be accommodated, particularly if family
cording to a clear division of labor. Assessing
uate, and can inadvertently contribute to creati
mother to speak on behalf of all family members
assessment process conveys a message that they
and priorities independently (May, 1988), yet t
ram's philosophical stance.

ip Between Measures and Program Intent, Organiza
cal Orientation

cant issue which all programs will need to resol
process is the overall relationship between the
d the stated objectives of the program itself.
high degree of congruence is desirable between

tes to the information gathering
at of several measures are eithe
clinical judgement and inference
iagnostic teams believe that the
ess reside exclusively with the
rt measures would be in conflict
rams assume that families must r
ures which require professional
s and dynamics may not be partic
The selection of assessment mea
essionals, and community service
rtant with respect to needs, con
, these measures will also conve
een parents and professionals, t
ram eligibility criteria, and th
ems in intervention.

Intrusiveness

Establishing trust between pare
creation of a working relationsh
ies a communication of respect f
lf slowly and in accordance with

process itself. More precisely, the
r parent self-report in design or demand
of the professional. Philosophically,
data gathering and needs determination
professional community, then family self-
with this perspective. Conversely, if
eveal their needs and priorities, then
inferential judgement regarding family
ularly helpful.
sures will communicate to families, EI
agencies what the program perceives to b
cerns, and priorities of families. More-
y the need for a collaborative relationsh
he key decision-making role of parents,
e role of other informal and formal suppo

nts and professionals is the first step i
ip (Friedman and Friedman, 1982). This
or a family to share information about
its own timetable. Such an evolution ma

Select measures which address parent priorities and strengths, rather than tools which depend upon a professional's assessment of parental deficiencies. The intent of information gathering is to assist in problem solving, not to determine causality (Trivette, 1987; Bristol, 1987). A strength-oriented approach is much more likely to increase trust than one which focuses on family pathology.

Select measures which address the areas perceived by both parents and professionals as within the purview of the program's direct focus (McGonigel and Garland, 1988).

Conceptualize a dynamic, evolutionary assessment process in which needs and priorities can be addressed over time in synchrony with the family's trust level and interest in sharing these needs and priorities with the professional.

Ensure that the clinical expertise of the early intervention professional is well developed. Families may not identify something as a need if they believe the problem is irresolvable (Dunst et al., 1987). In addition, professionals who are unaccustomed to appraising family structures, functions, and stresses may be reluctant to follow up on verbal and non-verbal communications by family members, an essential aspect of family needs identification. Training activities and continuing support for EI professionals are critical in developing new and unfamiliar helping behaviors related to the family need/

finition of Population Served: Screening, Assessment,
igibility Policies

.L. 99-457 creates a rich opportunity for programs to n
y services to developmentally disabled children, but al
plement more comprehensive and aggressive efforts devot
extent that programs are interested in both of the abo
ing and assessment models which incorporate child and f
es must be developed. While studies presented earlier
l in drafting such multivariate models, no reliable and
on making equation has yet been created. Consequently,
models are developed, careful field trial periods are
ale adoption. Significant evaluation questions which m
h pilot projects are as follows.

. What differences exist in the population identified
screening model in contrast with existing referral p
casefinding techniques? What specific factors in th
for these differences?

. What contribution does each screening factor (i.e.,

portunity to view eligibility from a fresh and novel vantag
nerating risk responsive, coordinated, and comprehensive IF
incipal outcome of child and family assessment, commitments
asures will invariably prompt a range of complex questions
e eligible EI population, but also the manner in which this
st appropriately served. Programs will need to develop app
chnically sound implementation plans such that the above re
estions may be answered.

Continuum of Services

Clearly, adoption of family focused measures in EI progr
ids in the existing range of service options, both for chil
milies. For example, parents may express interest in the u
ttings (e.g., family and center based day care environments
gly, programs may need to develop a productive, collaborati
pportive relationship with the overall child care community.
nge of family needs may emerge from the assessment process
ams, up to this point in time, have not been responsible.
re is not to suggest that EI sites must directly assume own

ponsibility among individuals, families, and communities'
4). Jeppson (1988) describes the aspects of such family-
luding:

- a view of the family as continuous in a child's life,
  providers and systems are transitory

- a focus which goes beyond a child's special needs tow
  family well-being and in normative developmental proc

- a comprehensive, flexible, and accessible service sys
  range of choices to families including parent-to-pare
  grams, equipment exchange options, transportation ass
  weekend and evening services

As early intervention programs begin to implement syste
essment practices, diverse and dynamic family needs and
ntified. Accordingly, new and creative methods of provi
latory. The insights of Hobbs et al. (1984) and Dunst et
ection as programs struggle to meet this challenge. The
ony points to developing interventions that always move
more drastic, from more normative to less normative, fro

It is to be expected that families will require highly var
ofessional involvement. Recognizing that no one program can
l the needs of all families, linkages between service systems
itical importance and cannot be underestimated. In addition,
tervention approaches which continually support the movement
ward their expressed level of independence from professional
so becomes a desired outcome.

Case Management

Significant implications are evident for the case manageme
ofessionals implement the family assessment and service plann
ceptional skill is involved in sorting out the roles, respons
endas of formal service providers, in assessing the potential
formal resources, in accessing or advocating for additional s
st importantly, in developing a collaborative relationship wi
pport their highest level of independent functioning.

Consider the case management implications for the followin
ildren/families referred for early intervention services.

Chris N. is 12 months old and has multiple delays in devel

t the present time. The protective services worker is unde
o arrive at a recommendation for the court within the next
ng a permanent disposition with respect to custody of Chris
arly intervention was arrived at unilaterally by the protec
orker, with the hope that Chris' delays in development coul
nd also to provide Trisha one more opportunity to demonstra
egaining custody of her child. Trisha has agreed to being
ntervention as a means of increasing her chances of getting
he is doubtful about its usefulness for herself, but is wor
on's delays and wants him to receive the professional help

Michelle H. is a three month old infant, about to leave
ome for the first time. She was born three months prematur
esulting from birth trauma, and is considered at high risk
elays. Michelle is the first child born to Fran and Peter
ork full-time at professional jobs. Fran's maternity leave
ithin 30 days. The previous arrangement for day care, whic
efore Michelle's birth, is no longer viable due to Michelle
eeds. Fran is considering requesting half-time employment.
ould provide enough income for the family and would allow

nd Parental Judgement

57 encourages EI profess

ssment and intervention,

cial workers, nurses, and

om the child-focused IEP

s are noteworthy.

all, all professionals c

administering the family

efforts to establish tru

Garland, 1988). Additi

and use of clinical obse

siasm, support, and comf

o the use of formalized

the successful implement

e merely tools. They ca

sionals of all disciplines to p

activities traditionally with

psychologists. As a program

to the child and family-focuse

on the team will need to develo

assessment tools within the c

sting relationships with famil

onally, skills in interviewing

rvation will require refinemen

ort level of professionals and

instruments and methods are es

ation of this process. Assess

n facilitate the diagnostic pr

the VNA and the early interven
Peter are appreciative of all
have received and will continu
hock regarding the disparity b
to function independently as p
nce on professionals in caring
he identification of family ne
he involvement of other servic
ions are essential to the deve
eatment plan. Fortunately, mo
useful structure within which
In brief, the components of th

of which systems are involved
tions regarding family needs,
ication of responsibilities o
ention process.

is of the pattern of relations

tion program to request services.
the professional help they and
e to receive, they continue to be
etween their previous expectations
arents and the reality of their
for their daughter.
eds/priorities/resources and an
e providers in these two hypo-
lopment of a comprehensive early
dels exist (Imber-Black, 1988)
these case management needs may
is representative model include:

, and of each provider's
strengths, and goals, and
f service providers in the

hips between families and each

larification of the varying perceptions of appropriate boundaries etween families and service systems, and among various service roviders. Difficulties may exist when a family has perceptions fferent than that of the service provider concerning degree of nvolvement. A family may desire more privacy, while an agency feels need to know more about family functioning and routines. Similarly, family may seek more information about an agency which may tend to lease information parsimoniously.

arification of the myths or beliefs families and service systems ve about each other, based on long-standing involvement or on ecific critical incidents for either party.

incipal objectives of a case management model are twofold: (1) to mentation and duplication in service delivery; and (2) to enable acquire skills for accessing, utilizing, evaluating, and advocating s via formal and informal resource avenues. Such models are dynamic linear or static (Friedman, 1988), and serve as the "glue which ystem together" (Aaronson, 1988). Significant considerations in zing a case management, or service advocacy and coordination model, ows.

del must articulate a "needs determination" process which commodates both parental and professional perspectives as well as

needs determination, process must accommodate both intra and agency service provider coordination and communication.

ss must include a mechanism for monitoring service effectiveness, ifying new needs, recording needs/service utilization relation- and eliminating duplication of services.

must articulate a continuum of dependence/independence which ts and encourages both varying and increasing degrees of "active" ption of case management functions by families.

must include requisite training activities for parents and ssionals regarding the overall process and facilitate and support ies achieving a maximum level of independence.

must articulate a flexible decision-making process regarding ry case manager designation with families involved with multiple ce providers.

ping a service advocacy and coordination model consistent with ciples, perhaps the most complex issue relates to the extent to can independently assume responsibility for such functions. The complexity relates not only to developing ways in which such nd skill can be accurately assessed, but also in creating ich prompt, encourage, and support families in achieving a of independence consistent with their interest and ability.

ssue, no unitary solution or model e
hich is consistent with an overall f
tion by both families and service pr
ollows is a self-appraisal inventory
ithin the assessment process. It is
esigned to serve as a stimulus for d
ithin the context of the development
his monograph.

exists. However, in developing a model
family assessment strategy, careful evalu-
roviders is essential. To this end, what
y which is intended for potential use
s critical to note that this inventory is
discussion among parents and professionals
tal, decision making process portrayed in

SERVICE ADVOCACY

A SELF-APPRAISAL FOR I

cipation in early intervention
ing, accessing, evaluating, a
. This process is most effec
a collaborative relationship,
are secured and well coordin
urpose of this self-appraisal
is process is functioning, an
ls assume in its implementati
d upon intake, and is updated
major component of the invent
ly rated by parents and profe
n ratings is not evident, ind
ote that there are no "right"
u are encouraged to use the f
iven point in time. The inve
status, but also serve as a s

Y AND COORDINATION:

PARENTS AND PROFESSIONALS

n programs involves an ongoing pro
nd coordinating services for child
tive when parents and professional
and together ensure that all nece
ated.

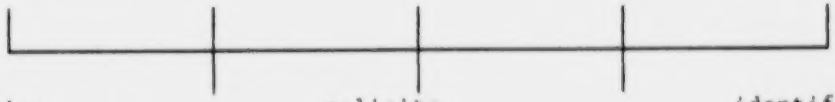
inventory is to describe the mann
d the role which both parents and
on. The inventory is designed to
at six month intervals thereafter
ory includes items which are inter
ssionals. In those instances wher
ividual ratings should be reported
or "desired" ratings on these ite
ull continuum to reflect your perc
ntory is intended to not only desc
timulus for establishing future go

Identification of Child and Family Needs

Parent

desires professionals to identify and prioritize child/family needs	identifies child/family needs via family and professional input	identifies child/family needs independent of professional input

Professional



relies upon parents to reveal significant child/family needs	solicits family's perspective in conjunction with professional judgement	identifies child/family needs independently of family input

Access to Community Based Services and Re

2.1 Knowledge of Resources: Parent

relies upon professionals to make available pertinent information

requests information from professiona as supplem to existing knowledge

Knowledge of Resources: Professiona

relies upon parents to generate resource information

shares available information with families upon request

sources

maintains
resource
directory
independently

ls
nt

l

maintains
resource
directory and
selectively
reveals
information
based upon
professional
judgement

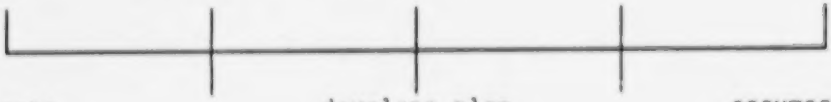
2 Access to Resources: Parent

relies upon professionals to secure access to necessary and desired services

negotiates shared responsibility for resource access with professionals

assumes responsibili for securing resources independentl

Access to Resources: Professional



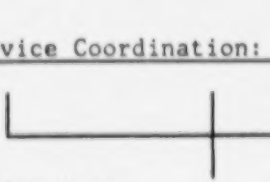
expects parents to pursue resources consistent with identified needs

develops plan for shared responsibility for resource access

assumes full responsibili for resource access

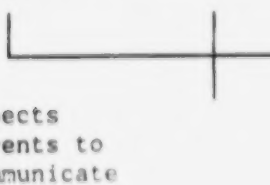
Coordination of Services

3.1 Service Coordination: P



relies upon
professionals
to communicate
with and
coordinate
service providers,
both internal
and external
to EI

Service Coordination: P



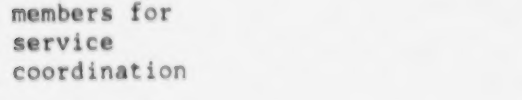
expects
parents to
communicate
with and
coordinate
service
providers

arent

establishes shared division of responsibility between professionals and family members for service coordination

independe coordinat multiple service providers

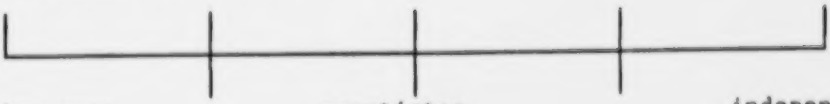
rofessional



develops plan for shared responsibility for service coordination

assumes f responsib for coord intragenc interagen providers

3.2 Conflict Resolution: Parent

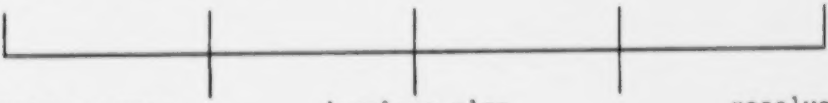


relies upon professionals to resolve difficulties with service access, duplication, or fragmentation

negotiates mutual division of labor with professionals for conflict resolution

independen resolves difficulti with servi access

Conflict Resolution: Professional



expects parents to independently resolve difficulties with service access and fragmentation

develops plan for shared responsibility for conflict resolution

resolves difficulti on behalf of parent

.0 Evaluation and Revision of Se

Parent

relies upon
professional
judgement
regarding
adequacy
of services

Professional

expects parent
to reveal
service
inadequacies
and pursue
appropriate
modification

ervices

develops criteria for evaluating services in collaboration with professionals

evaluates and pursues revision of services independent professional input

develops plan with family for assessing services, including identification of appropriate standards of care

evaluates services independentl and negotiat revision according to professional judgement

Utilization of Support System

Parent

relies exclusively upon professionals for service access and coordination

maintains and selectively uses network of formal and informal supports for service access and coordination

main
uses
info
syst
majo
iden
need

Professional

expects parents to develop and maintain informal support system for service access

assists parents in developing range of formal and informal supports for service access and coordination

uses
supp
syst
for
iden
chil
need

V. DEVELOPING AN IFSP FORMAT

A. IFSP Components as Defined by P.L. 99-457

Essential components of an IFSP as defined by P.L. 99-457 a

1. A statement of the infant's or toddler's present level
development, cognitive development, language and speech
psycho-social development and self-help skills, based
objective criteria.

This section appears to be congruent with the current IEP
important to note however, that several IFSP forms recently deve
1987; Bruder, 1987) specifically list child strengths as well as
allows parents to view their child's unique skills as well as de
needs, and permits a more complete and balanced portrayal of chi
functioning.

2. A statement of the family's strengths and needs relatin
the development of the family's handicapped infant or t

This segment of the IFSP is designed to accommodate finding
family assessment process. The value of including family streng
overemphasized. Professional recognition of family abilities is
component in the development of trust between families and profe
Furthermore, Dunst et al. (1988) define needs, not as family def
but rather as family "aspirations, projects, aims, priorities",
which the family considers important enough to devote time and e

studies conducted with families,
legitimately takes into account
are not always child related, bu
from focusing on the child's dev
se, housing, transportation, foo
in promoting the child's develop
parents identify this as a focal

3. A statement of the majo
infant and toddler and
timelines used to deter
achieving the outcomes
revisions of the outcom

Adoption of IFSP formats in
orientation which emphasizes str
table summarizes issues which pe
mental process, and which attemp
transition from IEPs to IFSPs.

Dunst et al. (1987) advance an approach w
those situations in which a family's prior
t unless addressed, will prevent the famil
elopment (e.g., lack of basic resources su
d). Needs statements regarding a family's
ment should be made only to the extent tha
concern.

r outcomes expected to be achieved for the
the family, and the criteria, procedures a
mine the degree to which progress toward
are being made and whether modifications o
es or services are necessary.

early intervention programs requires an
engths, needs, and resources. The followi
rhaps will warrant attention in this devel
t to identify significant considerations i

Table 1.

Comparison of IEP and IFSP Pract

ssue	IEP
of needs sment	child develop- mental needs
ion-making ss regard- ntervention ities	goals primarily determined by professionals
of vention	specific gains in the child's developmental status
frames of setting	long-term goals are established (i.e. annual, to be evaluated quarterly)
of vention	identification of the early intervention services to be provided to meet child goals

tices on Select Dimensions

IFSP
child and family strengths/needs/resources
parents and professionals have equal status in decision-making
the child within the context of the family, and the well-being of all family members and of the family as a unit
process must reflect the dynamic needs and priorities of families
identification of all formal and informal resources needed/accessed, with early intervention services identified as part of a more comprehensive plan

statement of specific early intervention services necessary to meet
e unique needs of the infant or toddler and the family, including
e frequency, intensity, and the method of delivering service.

et al. (1987) caution against the notion, embedded in this
, that "more is better". If a broadened perspective of intervention
veloped, then as discussed earlier, services which are community
ative for young children and their families, and which draw on a
tual or potential informal support network as well as other service
ld take precedence.

e projected dates for initiation of services and the anticipated
ration of such services. The name of the case manager from the
ofession most immediately relevant to the infant's and toddler's or
mily's needs will be responsible for the implementation of the plan
d coordination with other agencies and persons.

this stipulation underscores the importance of case management
within early intervention, it does not clarify the potential for
serve as their own case managers, or in partially assuming case
responsibilities. This is a disempowering message to families and
ssessed by each EI program carefully.

e steps to be taken supporting the transition of the handicapped
ddler to services provided by school districts.

tipulation requires that attention be paid to creating a planned

. Dynamic Formats

ssessment strategies which are truly needs based support frequent
e specification of needs, methods, and outcomes (Dunst et al.,
gard the use of a spiraling approach in which there is continuous
een needs identification and service provision (Turnbull, 1988).
ng process accommodates not only newly identified needs as the
e provider relationship strengthens, but also allows for unantici-
and events in the lives of families which may necessitate
intervention priorities.

tervention programs may discover that the relatively static
ntly used to portray goals and objectives in IEPs are not well
e synergistic process noted above. Consequently, IFSP forms will
eated which acknowledge this ongoing needs identification process,
l accept both new needs statements and intervention goals while
e fluidity and continuity of existing services.

iven vs. Professionally Driven Goals

e documentation exists in the literature with regard to the
lexity of the parent/professional relationship; underlying this
that the perspectives of parents and professionals are often
iley, 1987). To some extent, these disparities have emerged from
rams for service providers which have reinforced a model in which

not sharing vulnerabilities with parents

developing strategies to get parents to comply with professional prescriptions, even when they have been objected to overtly or covertly

being concerned with circumscribed areas of a child's functioning rather than the whole child within the context of the family

maintaining control of the information which parents receive about their children

using, as a measure of professional competence, facility in writing reports on children which are replete with the technical terms of the discipline

ır:ent societal presses regarding professional ethics, liability, and ology can contribute to undermining professional efforts to develop a borative approach in which parents and providers are both perceived as resourceful, having equal status, and being an equal partner in evalu- the services provided (Tyler et al, 1983; Bailey, 1987; Winton and y, 1988; Dunst et al., 1987). Considerable controversy exists on this , particularly with respect to family needs identification and goal ng. Bailey (1987) recommends that professionals not elude differences i s or priorities, but rather engage in dialogue for resolving these dif-

VI. TRAINING/TECHNICAL ASSISTANCE IMPLICATIONS

sment Skills

tion of competency in two major domains is essential
f a comprehensive family assessment and service plan
inistration and interpretation of assessment measur
amily focused interviewing and collaborative goal se
on professionals will need training experiences, bot
cal, which focus on the development of technical kno
on and interpretation of assessment tools. Within t
n dealing with family systems theory, normative, dev
es, and family structure and interaction processes a
areas.

ommunication involves an ability to "join" families,
port family strengths. Although program staff may b
onversing with parents about their children, they ma
derable discomfort when it comes to discussing famil
g/resources. Training strategies focused on develop

stand the family

licit the family's priorities for the child and for themselves.
ecognize and address the effects of various individual
haracteristics on the growth and development of the child and
amily

nderstand how a child with special needs affects parents,
iblings, the extended family, and the community

lish and maintain relations with the family

uccessfully initiate first contacts with families, even when
hey have not sought information

xplain to parents the role of the interventionist in working
ith the child and family

orm and maintain satisfactory working relationships with
nfants, toddlers, and families

ork with culturally different families in a non-biased and non-
alue-laden way

ommunicate respect for the values, ideas, suggestions, and
riorities of the family

rganize and encourage parent involvement in all phases of the
rogram

ddress areas of disagreement with families honestly in a
upportive and non-value-laden way

acilitate family decision-making concerning the needs of the
hild without imposing personal biases or supplanting family
uthority

ranslate and interpret technical information (e.g., test
esults) to families in understandable language

s issues/needs within families

leet family needs

.1 help families integrate the child's specialized routines into normal family activities

.2 create stimulating programs that draw on the child's strengths and that are consistent with the family's lifestyle

.3 encourage the family to rely appropriately on informal as well as formal support systems

.4 facilitate effective group support for parents' and siblings' education

.5 plan intervention strategies congruent with the parents' style of learning

.6 enhance parental competence, confidence, and self-esteem

.7 decrease or increase intervention time when appropriate

.8 support the family's increasing independence

.9 successfully terminate relationships with families when appropriate

Encourage the child's development within the context of family routines and activities

.1 explain the effects of various handicapping conditions on development

.2 explain to parents the nature of child development and sequences of skill acquisition

.3 discuss with parents the various medical, educational, and therapeutic techniques for special needs children

.4 involve families in developing goals for the child and strategies to meet them

.5 help families increase behaviors that positively affect the child's development and decrease behaviors that negatively affect it

7.0 Theory and research

7.1 major theories of family development and functioning

7.2 relevant research on the family's role in the development of the very young child

7.3 major theories of the family's role in the development of the child with special needs

7.4 relevant research on the family's role in the development of the child with special needs

In conclusion, P.L. 99-457 creates an enormous opportunity for states to op comprehensive polices which will affect the health, well-being, and l and educational competence of young children and their families. The us of such a dynamic and integrated system will be comprised of a precise houghtful appraisal of the needs of children and their families, and ermore, will test the upper limits of our ability to create responsive, ngful, and cost effective services which coincide with these needs. To xtent that states are committed to developing prospective plans which alize upon this opportunity for both intervention and prevention, careful tion to the developmental process described herein will hopefully provide text and perspective for generating viable and creative solutions.

Measures of Social

Scales	Source	References (see page 9)	In
"Ask About Your Child" Questionnaire	Meyers, Mink & Nihira	132	
Adolescent-Family Inventory of Life Events and Changes	McCubbin, Patterson, & Wilson	124	
Affect Balance Scale	Bradburn	30, 39	
Affect Intensity Measure	Larsen	99, 107	
Affectometer	Kammann & Flett	99, 102	
Beck Depression Inventory	Beck	8, 29	
Behavior Stress Index	Garyeth & Gottlieb	23, 86	
Bipolar Traits Inventory	Schaefer & Edgerton	175	
Carolina Parent Support Scale	Rested	14	
Child Expectation Scale	Durst	42	
Community Interaction Checklist	Walker	195, 196, 197, 198	
Coping Help Inventory for Parents	McCubbin, McCubbin, Nevin & Cauble	121, 122	
Daily Interaction Rating Form	Hirsch	80, 81	
Definition Scale	Rested	13	
Delighted-Terrible Scale	Andrews & Withey	4	
Differential Personality Questionnaire (Well Being Subscale)	Tellegen	88, 190	
Dual Employed Coping Scales	Skinner & McCubbin	182	
Family APGAR	Smilkstein	18, 183, 184	
Family Adaptation and Cohesion Evaluation Scales	Olson	150, 152, 153, 154, 171	
Family Coping Inventory	McCubbin, Boss, Wilson & Dahl	119	
Family Crisis Oriented Personal Scales	McCubbin, Olson & Larsen	123	
Family Educational Atmosphere Survey Instrument	Bolton-Brigham	64, 65, 66	
Family Environment Scale	Moos	141, 144, 145	
Family Functioning Index	Pless & Satterwhite	160, 161	

Table 1

l Support and Family Behavior

Social Support			Well-Being		Coping	Family Integrity	Parent Attitudes	Child Expectations	Relial Validi availa Table
trafamily	Kinship	Extrafamily	Physical	Emotional					
							X	X	
X	X	X		X	X	X			
				X					
							X		
							X		
			X	X					
				X					
							X	X	
X	X	X							
								X	
X	X	X							
					X				
X	X	X							
							X		
				X					
				X					
					X				
X					X				
X					X	X			
					X				
X	X	X		X					
X					X		X	X	
X				X	X	X			
X									
X					X				

Family Interview Scale	Rosenbaum
Family Inventory of Life Events and Changes	McCubbin, Pa & Wilson
Family Inventory of Resources for Management	McCubbin, C & Harkins
Family Relationships Index	Hudgham & M
Family Resource Scale	Leet & Dunst
Family Responsibility Inventory	Schaefer & F
Family Stress Index	Miller
Family Support Scale	Dunst, Jenkin Trivette
Family System Rating Scales	Lewis, Beaver & Austin Phil
General Psychological Well-Being Schedule	Dupuy
Group Environment Scale	Moos
Gurin Scale	Gurin, Veroff
Happiness Measures	Fordyce
Health Status Scale	Koch, Kowa & Klaw
Home Quality Rating Scale	Meyers, Minh
Hom-Hurst Questionnaire	Spielberger, Ludeke
Impact on Family Scale	Stein & Riess
Index of General Affect	Campbell, C Rodgers
Index of Psychiatric Symptoms	Gurin
Instrumental Expressive Support Scale	Lin, Dean &
Interpersonal Support Evaluation List	Cohen & Ho
Interview Schedule for Social Interaction	Clenc, Green Rogers, Rod Rachman
Inventory of Parent's Experiences	Clenc, Rogers Greenberg &
Inventory of Socially Supportive Behaviors	Barrera & A
Langer Mental Health Scale	Langer
Life Experience Survey	Sarason, Joh

	17, 19	X	X	X					
tterson	125	X	X	X		X	X	X	
mmers	120	X			X	X			
ton	42	X							
	119	X	X	X		X			
igerton	180	X							
	114				X	X			
&	43	X	X	X					
, Cosatti	112	X	X						
	91, 53				X	X			
	140, 142		X	X		X	X		
& Feld	91, 77					X			X
	91, 69								X
Harris	114				X				
& Nobre	133, 146	X	X						
lenmei.	185					X			
ton	186, 187	X	X			X	X		
ivers &	20								X
	76				X	X			
Fuel	111			X					
rman	10	X	X	X					
erg, wn &	12	X	X	X					
, Robinson	34	X	X	X					
ley	6, 7, 172, 188, 190	X	X	X					
	105, 126				X	X			
n &	173	X	X	X					

Marital Adjustment Scale	Locke & Wallace	117
Marital Coping Resources Questionnaire	Meanor	147, 148
Maternal Attitude Scale	Calder, Wiess, & Cronebaum	41
Maternal Developmental Expectations Childrearing Attitudes	Field	58, 59, 69
Maternal Social Support Index	Pascoe, Loda, Jeffries & Earp	155
Mood Survey	Underwood & Froming	194
Parent Needs Inventory	Fewell, Meyer & Schell	56
Parent Role Scale	Gallagher, Cross, Scharfman	46, 70, 71 179, 194
Parent Role Scale, Revised	Fewell, Meyer, Vadasy & Greenberg	57
Parent as Educator Interview	Schaefer & Edgerton	176, 178
Parental Expectation Scale	Schaefer & Edgerton	174
Parenting Stress Index	Abidin	1
Perceived Social Support	Procidano & Heller	164
Perceived Stress Index	Jacobs & Munz	100
Pregnancy Support Scale	Dunst & Vance	52
Profile of Mood States	McNair, Lorr & Droppleman	129
Psychological Well Being Index	Bradburn & Caplovitz	11, 66
Psychosocial Kinship Network Inventory	Pattison	146, 156, 157, 158
Quality of Life Scale	Beach	169, 170
Questionnaire on Family Support Systems	Fewell, Belmonte & Abbermeyer	55
Questionnaire on Resources and Stress	Holroyd	41, 96, 97, 98, 99
Questionnaire on Resources and Stress for Siblings	Greenberg, Vadasy & Meyer	75
Questionnaire on Resources and Stress: Revised	Greenberg	74
Questionnaire on Resources and	Friedrich, Greenberg	67

X								
X								
								X
							X	
X	X	X						
				X				
X					X			
X								
X								
							X	X
							X	X
				X				
X		X						
				X				
X	X	X						
				X				
				X				
X	X	X						
				X				
X	X	X		X	X			
X	X	X	X	X		X	X	X
X	X			X			X	X
X	X			X			X	X
X	X			X		X	X	X

Satisfaction with Parenting Scale	Bagozin, Basham, Crnic, Greenberg & Robinson	164, 165					
Satisfaction with Life Scale	Diener, Emmons, Larsen & Griffin	39, 40					
Satisfaction with Social Network Scale	Stokes	188, 189	X	X	X		
Schedule of Recent Experiences	Holmes & Rahe	95	X	X	X		
Self Rating Depression Scale	Zung	204				X	
Social Assets Inventory	Schaefer & Edgerton	177					
Social Network List	Hirsch	82, 85, 162	X	X	X		
Social Network Rating Scale	Hirsch	83	X	X	X		
Social Network Scale	Kaplan	103, 118, 135	X	X			
Social Readjustment Rating Scale	Holmes & Rahe	94	X	X	X		
Social Relationship Scale	McFarlane	127, 128	X	X		X	
Social Resource Measures	Zautra, Beier & Cappel	203	X	X	X		
Social Support Measure	Crnic, Greenberg, Ragozin, Robinson & Basham	33	X	X	X		
Social Support Rating Scales	Carveth & Gottlieb	24	X	X	X		
Social Support Life Events Questionnaire	Shamgar & Leslau	181	X	X			
Social System Scale	Hirsch	84, 85, 89	X	X	X		
Survey for Parents of Children with Handicapping Conditions	Moore, Hamerlynck, Barsh, Spieker & Jones	139	X	X	X		
The Adaptive Potential for Pregnancy Scale (TAPPS)	Nuckolls	147, 148, 149	X	X	X		
Traditional Social Support Index	Holahan & Moos	91, 93	X	X	X		
Work Environment Scale	Moos & Insel	143			X		
Work Relationships Index	Holahan & Moos	93			X		

			X	X	
X					
X					
			X	X	
					X
X					
X	X				
X	X				X

Appendix B.

Reliability/Validity of Measures

of Social Support and Family Behaviors*

Table 2

Reliability and Validity of the

Scales	References (see page 9)	Reliability			
		Internal Consistency	Short-Term Test-Retest	Long Term Test-Retest	Alter Fo
nt Family Inventory of Events and Changes	124	r_s = .67 – .89	r_s = .69 – .90		
ntensity Measure	39, 107, 194				
ucter	4, 10, 39, 102				
Help Inventory for Parents	121, 122, 141	r_s = .71 – .79			
nteraction Rating Form	80, 81, 85				
APGAR	38, 160, 183, 184	r_s = .24 – .67 r = .93			
Adaptation and Cohesion ation Scales	151, 152, 153, 154, 171	r_s = .80 – .91	r_s = .80 – .84		
Coping Inventory	119	r_s = .71 – .86			

e Scales

	Validity	
nate ms	Factor Structure (# of Dimensions)	Criterion
	6	r_s = .13 and .16 with Health Locus of Control (Wallston, Wallston, & DeVellis, 1978)
		Diener (1984) reported moderate to high correlation with Mood Survey (Underwood & Froming, 1980)
		r = .73 with Bradburn Affect Balance (Bradburn, 1969) r = .63 with Delighted-Terrible Scale (Andrews & Withey, 1976)
	3	r_s = .00 - .36 with Family Environment Scale (Moos, 1974)
		r = .53 with Social Systems Scale (Hirsch, 1979)
		r = .80 with Family Functioning Index (Pless & Satterwhite, 1973)
	4	
	3-5	t_s = 2.01 - 4.58 ($p < .05$) between the Maintaining Family Integrity; Developing Interpersonal Relationships and Social Support; Managing Psychological Tension and Strain; Acceptance of Lifestyle and Optimism; Developing Self Reliance and Self Esteem; and Balanced Coping Strategy subscales for distressed vs. nondistressed wives

Family Inventory of Life Events and Changes	125, 131	
Family Inventory of Resources for Management	120, 141	r = .89 r_s = .44 .85
Family Relationships Index	92	r = .89
Family Support Scale	43, 96	r_s = .75 .85
Family System Rating Scales	112	r_s = .47 .82
Happiness Measures	10, 39, 60, 108	
Impact on Family Scale	186, 187	r_s = .60 .88
Instrumental Expressive Support Scale	113, 130	
Interview Schedule for Social Interaction	32	r_s = .50 .61
Inventory of Socially Supportive Behaviors	5, 6, 7, 172 188, 190	r = .94
Marital Adjustment Scale	117	r_s = .84 .90

				9	r_{tt} = .44 – .81 between intratotal streams and Family Environment Scale (Moos, 1974) r_{tt} = .90 – .94 between total scale scores and Family Environment Scale (Moos, 1974)
				6	r_{tt} = .92 – .96 with Family Environment Scale (Moos, 1974)
	r = .91	r = .47		6	r_{tt} = .18 – .21 with Questionnaire on Resources and Stress—Poor Health and Moral, Excess Time Demand, Lack of Family Integration, and Limits of Family Objectives subscales (Holroyd, 1973)
					r_{tt} = .30 – .90 with Global Family Health Pathology Scale (Lewis, et al., 1976)
	r_{tt} = .67 – .86				Dreyer (1984) reported high to substantial correlation with Affect Balance Scale (Bradburn, 1969)
				4	
				5	r = .55 with Medalie-Goldbourt Scale (Medalie & Goldbourt, 1976)
				3	
	r = .88 r_{tt} = .41 – .91			4	r_{tt} = .32 – .42 with Arizona Social Support Interview Schedule (Barrera, 1980)
					r = .47 with independent measure of adjustment t = 17.5 ($p < .01$) between adjusted vs. maladjusted groups

Marital Coping Resources Questionnaire	137, 138	r = .77	r = .65
Parent Role Scale	30, 70, 71, 179, 193		r_{tt} = .6
Parent as Educator Interview	176, 178	r_{tt} = .88 - .90	
Perceived Social Support	163	r = .90	r = .87
Questionnaire on Resources and Stress: Short-Form	8, 67		
Social Relationship Scale	127, 128		r_{tt} = .6 r_{tt} = .5
Work Relationships Index	93	r = .88	

Appendix C.

Family Needs, Resources, Strengths Scales

Family Resource Scale
Resource Scale for Teenage Mothers
Family Needs Scale
A Survey of Family Needs

Name _____

This scale is designed to assess whether
energy, and so on) to meet the needs of
For each item, please circle the response
in your family (that is, month-in and mo

To what extent are the following resources adequate for your family:

1. Food for 2 meals a day .....
2. House or apartment .....
3. Money to buy necessities.....
4. Enough clothes for your family .....
5. Heat for your house or apartment ..
6. Indoor plumbing/water .....
7. Money to pay monthly bills .....
8. Good job for yourself or spouse/pa
9. Medical care for your family .....
10. Public assistance (SSI, AFDC, Medi
etc.) .....
11. Dependable transportation (own car
provided by others) .....
12. Time to get enough sleep/rest .....
13. Furniture for your home or apartme
14. Time to be by yourself.....
15. Time for family to be together.....
16. Time to be with your child(ren).....
17. Time to be with spouse or partner.
18. Time to be with close friend(s).....
19. Telephone or access to a phone.....
20. Babysitting for your child(ren).....
21. Child care/day care for your
child(ren) .....
22. Money to buy special equipment/
supplies for child(ren) .....
23. Dental care for your family .....
24. Someone to talk to .....
25. Time to socialize .....
26. Time to keep in shape and look nic
27. Toys for your child(ren).....
28. Money to buy things for yourself...

Family Resource Scale

Hope E. Leet & Carl J. Dunst

Date _____

or not you and your family have adequate resources (time, money,
he family as a whole as well as the needs of individual family members.
that best describes how well the needs are met on a consistent basis
th-out).

	Does Not Apply	Not at All Adequate	Seldom Adequate	Sometimes Adequate	Usually Adequate	Almost Always Adequate
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
ther.	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
aid,						
.....	NA	1	2	3	4	5
or						
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
nt ...	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
.....	NA	1	2	3	4	5
..

Carl

Name _____

This scale is designed to see wh
needs and the needs of your child
are met on a day-to-day basis.

To what extent are the following
adequate for your family and/or y

1. Food for 2 meals a day .....
2. House or apartment .....
3. Money to buy necessities.....
4. Enough clothes for you and yo
5. Heat for your house or apart
6. Indoor plumbing/water .....
7. Money to pay monthly bills ...
8. Medical care for you and your
9. The time and resources (trans
care, etc.) necessary to coop
10. Public assistance (SSI, AFDC,
11. Dependable transportation (ow
provided by others) .....
12. The time and resources (transp
care, etc.) necessary to hold
13. Time to get enough sleep/rest .
14. Furniture for your home or apa
15. Time to be by yourself.....
16. Time to be with your child(ren)
17. Time to be with spouse or boyf
18. Telephone or access to a phone.
19. Knowledge of birth control meth
20. Babysitting for your child(ren),
21. A safe environment to live in...
22. Dental care for you and your chi
23. Someone to talk to .....
24. Time to be with friends.....
25. Knowledge of how to take care of
26. Time to keep in shape and look n
27. Toys for your child(ren).....
28. Money to buy things for yourself

Resource Scale for Teenage Mothers

Dunst, Hope E. Leet, Sherra D. Vance, & Carolyn S. Cooper

_____ Date _____

er or not you have adequate resources (money, time, energy, etc.) to meet y
ren). For each item please circle the number that best describes how well t

esources ur child(ren))	Does Not Apply	Not at All Adequate	Seldom Adequate	Sometimes Adequate	Usually Adequate
.....	NA	1	2	3	4
.....	NA	1	2	3	4
.....	NA	1	2	3	4
our child(ren).....	NA	1	2	3	4
ent	NA	1	2	3	4
.....	NA	1	2	3	4
.....	NA	1	2	3	4
r child(ren).....	NA	1	2	3	4
portation, child....					
plete school.....	NA	1	2	3	4
, Medicaid, etc.) ...	NA	1	2	3	4
n car or					
.....	NA	1	2	3	4
portation, child....					
d down a job.....	NA	1	2	3	4
.....	NA	1	2	3	4
partment	NA	1	2	3	4
.....	NA	1	2	3	4
en).....	NA	1	2	3	4
friend.....	NA	1	2	3	4
e.....	NA	1	2	3	4
ethods.....	NA	1	2	3	4
en).....	NA	1	2	3	4
h.....	NA	1	2	3	4
child(ren).....	NA	1	2	3	4
.....	NA	1	2	3	4
.....	NA	1	2	3	4
e of your child(ren).	NA	1	2	3	4
ok nice.....	NA	1	2	3	4
.....	NA	1	2	3	4
self.....	NA	1	2	3	4

Family Needs Scale

Carl J. Dunst, Carolyn J. Cooper, Janet C. Weeldreyer, Kathy D. Snyder, & Joyce H. Chase

Name _____ Date _____

This scale asks you to indicate if you have a need for any type of help or assistance in 41 different areas. Please circle the response that best describes how you feel about needing help in those areas.

To what extent do you feel a need for any of the following types of help or assistance:	Does Not Apply	Almost Never	Seldom	Sometimes	Often	Almost Always
1. Having money to buy necessities and pay bills.....	NA	1	2	3	4	5
2. Budgeting money.....	NA	1	2	3	4	5
3. Paying for special needs of my child.....	NA	1	2	3	4	5
4. Saving money for the future.....	NA	1	2	3	4	5
5. Having clean water to drink.....	NA	1	2	3	4	5
6. Having food for two meals for my family.....	NA	1	2	3	4	5
7. Having time to cook healthy meals for my family.....	NA	1	2	3	4	5
8. Feeding my child.....	NA	1	2	3	4	5
9. Getting a place to live.....	NA	1	2	3	4	5
10. Having plumbing, lighting, heat.....	NA	1	2	3	4	5
11. Getting furniture, clothes, toys.....	NA	1	2	3	4	5
12. Completing chores, repairs, home improvements.....	NA	1	2	3	4	5
13. Adapting my house for my child.....	NA	1	2	3	4	5
14. Getting a job.....	NA	1	2	3	4	5
15. Having a satisfying job.....	NA	1	2	3	4	5
16. Planning for future job of my child.....	NA	1	2	3	4	5
17. Getting where I need to go.....	NA	1	2	3	4	5
18. Getting in touch with people I need to talk to.....	NA	1	2	3	4	5
19. Transporting my child.....	NA	1	2	3	4	5
20. Having special travel equipment for my child.....	NA	1	2	3	4	5
21. Finding someone to talk to about my child.....	NA	1	2	3	4	5
22. Having someone to talk to.....	NA	1	2	3	4	5
23. Having medical and dental care for my family.....	NA	1	2	3	4	5
24. Having time to take care of myself.....	NA	1	2	3	4	5
25. Having emergency health care.....	NA	1	2	3	4	5
26. Finding special dental and medical care for my child.	NA	1	2	3	4	5
27. Planning for future health needs.....	NA	1	2	3	4	5
28. Managing the daily needs of my child at home.....	NA	1	2	3	4	5
29. Caring for my child during work hours.....	NA	1	2	3	4	5
30. Having emergency child care.....	NA	1	2	3	4	5
31. Getting respite care for my child.....	NA	1	2	3	4	5
32. Finding care for my child in the future.....	NA	1	2	3	4	5
33. Finding a school placement for my child.....	NA	1	2	3	4	5
34. Getting equipment or therapy for my child.....	NA	1	2	3	4	5
35. Having time to take my child to appointments.....	NA	1	2	3	4	5
36. Exploring future educational options for my child....	NA	1	2	3	4	5
37. Expanding my education, skills, and interests.....	NA	1	2	3	4	5
38. Doing things that I enjoy.....	NA	1	2	3	4	5
39. Doing things with my family.....	NA	1	2	3	4	5
40. Participation in parent groups or clubs.....	NA	1	2	3	4	5
41. Traveling/vacationing with my child.....	NA	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and Guidelines for Practice. Cambridge, MA: Brookline Books. May be reproduced.

[redacted] - FAMILIES 8/85 Child's Name/ID _____

Date: ___/___/___ Child's Birthdate ___/___/___

_____

Respondent's relationship to child: _____

A Survey of Family Needs

Listed below are some of the needs expressed by parents of special children. We are interested in what you would like help with. Please read each statement. If it is definitely not a need for you at this time, circle number 1. If you are not sure about whether you would like help in this area, circle number 2. If it is definitely a need for you and you would like help at this time, please circle number 3.

NEED	I definitely do not need help with this	Not Sure	I definitely need help with this
A. Needs for Information			
1. I need more information about my child's condition or disability	1	2	3
2. I need more information about how to handle my child's behavior	1	2	3
3. I need more information about how to teach my child	1	2	3
4. I need more more information on how to play with or talk to my child	1	2	3
5. I need more information on the services that are presently available for my child	1	2	3
6. I need more information about the services that my child might receive in the future	1	2	3
7. I need more information about how children grow and develop	1	2	3
B. Needs for Support			
1. I need to have someone in my family that I can talk to more about problems	1	2	3
2. I need to have more friends that I can talk to	1	2	3

NEED	I definitely do not need help with this	Not Sure	I definitely need help with this
3. I need to have more opportunities to meet and talk with other parents of handicapped children	1	2	3
4. I need to have more time just to talk with my child's teacher or therapist	1	2	3
5. I would like to meet more regularly with a counselor (psychologist, social worker, psychiatrist) to talk about problems	1	2	3
6. I need to talk more to a minister who could help me deal with problems	1	2	3
7. I need reading material about other parents who have a child similar to mine	1	2	3
8. I need to have more time for myself	1	2	3
Explaining to Others			
1. I need more help in how to explain my child's condition to his/her siblings	1	2	3
2. I need more help in explaining my child's condition to either my parents or my spouse's parents	1	2	3
3. My spouse needs help in understanding and accepting this child's condition	1	2	3
4. I need help in knowing how to respond when friends, neighbors, or strangers ask questions about my child's condition	1	2	3
5. I need help in explaining my child's condition to other children	1	2	3
Community Services			
1. I need help locating a doctor who understands me and my child's needs	1	2	3
2. I need help locating a dentist who will see my child	1	2	3

NEED	I definitely do not need help with this	Not Sure	I definitely need help with this
3. I need help locating babysitters or respite care providers who are willing and able to care for my child	1	2	3
4. I need help locating a day care center or preschool for my child	1	2	3
5. I need help in getting appropriate care for my child in our church or synagogue nursery during church services	1	2	3
Financial Needs			
1. I need more help in paying for expenses such as food, housing, medical care, clothing, or transportation	1	2	3
2. I need more help in getting special equipment for my child's needs	1	2	3
3. I need more help in paying for therapy, day care, or other services my child needs	1	2	3
4. I or my spouse need more counseling or help in getting a job	1	2	3
5. I need more help paying for babysitting or respite care	1	2	3
6. I need more help paying for toys that my child needs	1	2	3
Family Functioning			
1. Our family needs help in discussing problems and reaching solutions	1	2	3
2. Our family needs help in learning how to support each other during difficult times	1	2	3
3. Our family needs help in deciding who will do household chores, child care, and other family tasks	1	2	3
4. Our family needs help in deciding on and doing recreational activities	1	2	3

Appendix D.

Social Support Scales

Carolina Parent Support Scale
Family Support Scale
Inventory of Social Support
Personal Network Matrix

SUPPORT PROJECT
CIRCLE II
(May 1983 Version)

CAROLINA PARENT SUPPORT SCALE

CHILDHOOD VERSION
(Two-Parent Families)

Code = 7 if DK
Code = 8 if NA
Code = 9 for Column #21

NA = Not Available
DC = Available, but No Contact with them

	NA	DC	NOT AT ALL HELPFUL	SOMEWHAT HELPFUL	MODERATELY HELPFUL	QUITE HELPFUL	EXTREMELY HELPFUL
2. Husband (or wife)	NA	DC	0	1	2	3	4
3. My relatives	NA	DC	0	1	2	3	4
4. My husband's (or wife's) relatives	NA	DC	0	1	2	3	4
5. My own children	NA	DC	0	1	2	3	4
6. Friends	NA	DC	0	1	2	3	4
7. Other parents of children with special needs (informal)	NA	DC	0	1	2	3	4
8. Parent groups for parents of special children	NA	DC	0	1	2	3	4
9. Neighbors	NA	DC	0	1	2	3	4
10. Babysitter	NA	DC	0	1	2	3	4
11. Medical doctor	NA	DC	0	1	2	3	4
12. Church or clergy	NA	DC	0	1	2	3	4
13. Social parent services	NA	DC	0	1	2	3	4
14. Other parent training or counseling	NA	DC	0	1	2	3	4
15. TEACCH program	NA	DC	0	1	2	3	4
16. Other special education program	NA	DC	0	1	2	3	4
17. Mental Health Center	NA	DC	0	1	2	3	4
18. Developmental Evaluation Center (DEC)	NA	DC	0	1	2	3	4
19. Social Services	NA	DC	0	1	2	3	4
20. Day Care Program	NA	DC	0	1	2	3	4
21. Respite Care Program	NA	DC	0	1	2	3	4

(1-19)

Carlson, 1983, revised 1984, 1985
Adapted, with permission, from the Parent Support Scale by B. Bristol and others

SUPPORT SCALE
CHECK II
May 1983 Version)

CAROLINA PARENT SUPPORT SCALE

CHILDHOOD VERSION
(Single-Parent Families)

FOR FPG USE ONLY
Card Number: ___ (1-2)
(Duplicate Columns #3-19)

Code = 5 i[illegible] 6 ?2

= Not Available
= Available, but No Contact with this

	NA	NC	NOT AT ALL HELPFUL	SOMEWHAT HELPFUL	MODERATELY HELPFUL	QUITE HELPFUL	EXTREMELY HELPFUL
1. My boyfriend/partner	NA	NC	0	1	2	3	4
2. Child's father	NA	NC	0	1	2	3	4
My relatives	NA	NC	0	1	2	3	4
4. Child's father's relatives	NA	NC	0	1	2	3	4
5. My own children	NA	NC	0	1	2	3	4
6. My [illegible]	NA	NC	0	1	2	3	4
7. Other parents of children with special needs (informal)	NA	NC	0	1	2	3	4
8. Parent group for parents of special children	NA	NC	0	1	2	3	4
9. Neighbors	NA	NC	0	1	2	3	4
10. Babysitter	NA	NC	0	1	2	3	4
11. Medical doctor	NA	NC	0	1	2	3	4
12. Church or synagogue	NA	NC	0	1	2	3	4
13. Social agency [illegible] services	NA	NC	0	1	2	3	4
14. Other person trained in counseling	NA	NC	0	1	2	3	4
15. (Name of Program) educational program for child	NA	NC	0	1	2	3	4
16. Other special education programs	NA	NC	0	1	2	3	4
17. Mental health center	NA	NC	0	1	2	3	4
18. Developmental Evaluation Center (DEC)	NA	NC	0	1	2	3	4
19. Social Services	NA	NC	0	1	2	3	4
20. [illegible]	NA	NC	0	1	2	3	4
21. Respite Care Program	NA	NC	0	1	2	3	4

(over)

Bristol, 1982, revised [illegible], 1983
Adapted, with permission, from the work of M. [illegible]

Family Support Scale

Carl J. Dunst, Vicki Jenkins, & Carol M. Trivette

Name _____ Date _____

Listed below are people and groups that oftentimes are helpful to members of a family raising a young child. This questionnaire asks you to indicate how helpful each source is to your family. Please circle the response that best describes how helpful the sources have been to your family during the past 3 to 6 months. If a source of help has not been available to your family during this period of time, circle the NA (Not Available) response.

How helpful has each of the following been to you in terms of raising your child(ren):	Not Available	Not at all Helpful	Sometimes Helpful	Generally Helpful	Very Helpful	Extremely Helpful
1. My parents	NA	1	2	3	4	5
2. My spouse or partner's parents	NA	1	2	3	4	5
3. My relatives/kin	NA	1	2	3	4	5
4. My spouse or partner's relatives/kin	NA	1	2	3	4	5
5. Spouse or partner	NA	1	2	3	4	5
6. My friends	NA	1	2	3	4	5
7. My spouse or partner's friends	NA	1	2	3	4	5
8. My own children	NA	1	2	3	4	5
9. Other parents	NA	1	2	3	4	5
10. Co-workers	NA	1	2	3	4	5
11. Parent groups	NA	1	2	3	4	5
12. Social groups/clubs	NA	1	2	3	4	5
13. Church members/minister	NA	1	2	3	4	5
14. My family or child's physician	NA	1	2	3	4	5
15. Early childhood intervention program	NA	1	2	3	4	5
16. School/day care center	NA	1	2	3	4	5
17. Professional helpers (social workers, therapists, teachers, etc.)	NA	1	2	3	4	5
18. Professional agencies (public health, social services, mental health, etc.)	NA	1	2	3	4	5
19. _____	NA	1	2	3	4	5
20. _____	NA	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and Guidelines for Practice. Cambridge, MA: Brookline Books. May be reproduced.

INVENTORY OF SOCIAL SUPPORT

Carol M. Trivette Carl J. Dunst

NAME _____ DATE _____

DIRECTIONS

This questionnaire asks about people and groups that may provide you help and assistance. The scale is divided into two parts. Please read the instructions that go with each part before completing each section of the questionnaire.

Listed below are different individuals and groups that people often have contact with face-to-face, in a group, or by telephone. For each source listed, please indicate how often you have been in contact with each person or group during the <u>past month</u>. Please indicate any person or group with whom you have had contact not included on the list.

How frequently have you had contact with each of the following during the <u>past month</u>:	Not At All	Once or Twice	Up To 10 Times	Up To 20 Times	Almost Every-Day
1. Spouse or Partner	1	2	3	4	5
2. My Children	1	2	3	4	5
3. My Parents	1	2	3	4	5
4. Spouse or Partner's Parents	1	2	3	4	5
5. My Sister/Brother	1	2	3	4	5
6. My Spouse or Partner's Sister/Brother	1	2	3	4	5
7. Other Relatives	1	2	3	4	5
8. Friends	1	2	3	4	5
9. Neighbors	1	2	3	4	5
10. Church Members/Minister	1	2	3	4	5
11. Co-Workers	1	2	3	4	5
12. Babysitter, Daycare or School	1	2	3	4	5
13. Private Therapist for Child	1	2	3	4	5
14. Child/Family Doctors	1	2	3	4	5
15. Early Childhood Intervention Program	1	2	3	4	5
16. Health Department	1	2	3	4	5
17. Social Service Department	1	2	3	4	5
18. Other Agencies	1	2	3	4	5
19. _____	1	2	3	4	5
20. _____	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). <u>Enabling and Empowering Families: Principles and Guidelines for Practice</u>. Cambridge, MA: Brookline Books. May be reproduced.

INSTR

Listed below are 12 different types of help and assistance that people sometimes need and 19 different assistance listed, please indicate which persons or groups you go to when you need these types of help

Which persons or groups listed to the right provide you help or assistance with each of the following:	Myself	Spouse or Partner	My Children	My Parents	Spouse or Partner's Parents	Sister/ Brother	Spouse or Partner's Sister/ Brother	Other Relatives
1. Who do you go to for help or to talk with?								
2. Who helps take care of your child?								
3. Who do you talk to when you have questions about raising your child?								
4. Who loans you money when you need it?								
5. Who encourages or keeps you going when things get hard?								
6. Who accepts your child regardless of how (s)he behaves or acts?								
7. Who helps you with household chores?								
8. Who do you do things with to have fun, just relax, or joke around?								
9. Who takes the time to do things with your child?								
10. Who takes you and your child places when you need transportation?								
11. Who hassels with agencies and individuals when you feel you can't get what you need or want?								
12. Who helps you learn about services for your child and family?								

UCTIONS

people and groups who sometimes are asked for help and assistance. For each of the 12 types of help and . Indicate who provides you help by checking the appropriate box for the person or group you ask for help.

Friends	Neighbors	Church Members/ Minister	Co-Workers	Babysitter, Day care or School	Private Therapist for Child	Child/ Family Doctors	Early Childhood Intervention Program	Health Depart.	Social Services Depart.	Other Agencies

PERSONAL NETWORK MATRIX

Carol M. Trivette Carl J. Dunst

NAME _____ DATE _____

DIRECTIONS

This questionnaire asks about people and groups that may provide you help and assistance. The scale is divided into three parts. Please read the instructions that go with each part before completing each section of the questionnaire.

Listed below are different individuals and groups that people often have contact with face to face, in a group or by telephone. Please indicate for each source listed how often you have been in contact with each person or group during the past month. Please include any other person or group with whom you have had contact not included on our list.

How frequently have you had contact with each of the following during the past month:	Not At All	Once or Twice	Up To 10 Times	Up To 20 Times	Almost Every Day
1. Spouse of Partner	1	2	3	4	5
2. My Children	1	2	3	4	5
3. My Parents	1	2	3	4	5
4. Spouse or Partner's Parents	1	2	3	4	5
5. Sister/Brother	1	2	3	4	5
6. Spouse or Partner's Sister/Brother	1	2	3	4	5
7. Other Relatives	1	2	3	4	5
8. Friends	1	2	3	4	5
9. Neighbors	1	2	3	4	5
10. Church Members	1	2	3	4	5
11. Minister, Priest, or Rabbi	1	2	3	4	5
12. Co-Workers	1	2	3	4	5
13. Baby Sitter	1	2	3	4	5
14. Day Care or School	1	2	3	4	5
15. Private Therapist for Child	1	2	3	4	5
16. Child/Family Doctors	1	2	3	4	5
17. Early Childhood Intervention Program	1	2	3	4	5
18. Hospital/Special Clinics	1	2	3	4	5
19. Health Department	1	2	3	4	5
20. Social Service Department	1	2	3	4	5
21. Other Agencies	1	2	3	4	5
22. _____	1	2	3	4	5
23. _____	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and Guidelines for Practice. Cambridge, MA: Brookline Books. May be reproduced.

INSTRUCTIONS

This part of the scale asks you to do two things: (1) Begin by listing up to 10 needs or activities that are of concern to you. We call these things projects because they require our time and energy. Projects include things like finding a job, paying the bills, finishing school, playing with our children, going on vacation, teaching your child how to eat, and so on. (2) After you have listed up to 10 projects, please indicate which persons or groups you could go to if you need help with any of the projects. Indicate who would provide you help by checking the appropriate box for the person or group that you would ask.

Which person or groups to the right would you go to for help with any of these projects: / Projects	Myself	Spouse or Partner	My Children	My Parents	Spouse or Partner's Parents	Sister/ Brother	Spouse or Partner's Sister/ Brother	Other Relatives	Friends	Neighbors	Church Members/ Minister	Co-Workers	Baby Sitter, Day care or School	Private Therapist for Child	Child/ Family Doctors	Early Childhood Intervention Program	Health Dept.	Social Services Dept.	Other Agencies
1.																			
2.																			
3.																			
4.																			
5.																			
6.																			
7.																			
8.																			
9.																			
10.																			

Whenever a person needs help or assistance, he or she generally can depend upon certain persons or groups more than others. Listed below are different individuals, groups, and agencies that you might ask for help or assistance. For each source listed, please indicate to what extent you could depend upon each person or group if you needed any type of help.

To what extent can you depend upon any of the following for help or assistance when you need it:	Not at All	Sometimes	Occasionally	Most of the Time	All of the Time
1. Spouse or Partner	1	2	3	4	5
2. My Children	1	2	3	4	5
3. My Parents	1	2	3	4	5
4. Spouse or Partner's Parents	1	2	3	4	5
5. My Sister/Brother	1	2	3	4	5
6. My Spouse or Partner's Sister/Brother	1	2	3	4	5
7. Other Relatives	1	2	3	4	5
8. Friends	1	2	3	4	5
9. Neighbors	1	2	3	4	5
10. Church Members	1	2	3	4	5
11. Minister, Priest, Rabbi	1	2	3	4	5
12. Co-Workers	1	2	3	4	5
13. Baby Sitter	1	2	3	4	5
14. Day Care or School	1	2	3	4	5
15. Private Therapist for Child	1	2	3	4	5
16. Child/Family Doctors	1	2	3	4	5
17. Early Childhood Intervention Program	1	2	3	4	5
18. Hospital/Special Clinics	1	2	3	4	5
19. Health Departments	1	2	3	4	5
20. Social Service Department	1	2	3	4	5
21. Other Agencies	1	2	3	4	5
22. _____	1	2	3	4	5
23. _____	1	2	3	4	5

Source: C. J. Dunst, C. M. Trivette, and A. G. Deal (1987). Enabling and Empowering Families: Principles and and Guidelines for Practice. Cambridge, MA: Brookline Books. May be reproduced.

Appendix E.

Significant Life Stressor Scales

Family Inventory of Life Events and Changes
Life Experience Survey

FILE

Hamilton I. McCubbin, Joan M. Patterson & Lance R. Wilson

I. Intra-Family Strains
1. Increase of husband/father's time away from family.
2. Increase of wife/mother's time away from family.
3. A member appears to have emotional problems.
4. A member appears to depend on alcohol or drugs.
5. Increase in conflict between husband and wife.
6. Increase in arguments between parent(s) and child(ren).
7. Increase in conflict among children in the family.
8. Increased difficulty in managing teenage child(ren).
9. Increased difficulty in managing school age child(ren) (6-12 yrs.).
10. Increased difficulty in managing preschool age child(ren) (2 1/2-6 yrs.).
11. Increased difficulty in managing toddler(s) (1-2 1/2 yrs.).
12. Increased difficulty in managing infant(s) (0-1 yrs.).
13. Increase in the amount of "outside activities" which the child(ren) are involved in.
14. Increased disagreement about a member's friends or activities.
15. Increase in the number of problems or issues which don't get resolved.
16. Increase in the number of tasks or chores which don't get done.
17. Increased conflict with in-laws or relatives.

II. Marital Status
18. Spouse/parent was separated or divorced.
19. Spouse/parent has an "affair."
20. Increased difficulty in resolving issues with a "former" or separated spouse.
21. Increased difficulty with sexual relationship between husband and wife.

III. Pregnancy and Childbearing Strains
22. Family member experiencing menopause.
23. Spouse had unwanted or difficult pregnancy.
24. An unmarried member became pregnant.
25. A member had an abortion.
26. A member gave birth to or adopted a child.

IV. Finance and Business Strains
27. Took out a loan or refinanced a loan to cover increased expenses.
28. Went on welfare.
29. Change in conditions (economic, political, weather) which hurts family investments and/or income.
30. Change in Agriculture Market, Stock Market, or Land Values which hurts family investments and/or income.
31. A member started a new business.
32. Purchased or built a home.
33. A member purchased a car or other major item.
34. Increasing financial debts due to over-use of credit cards.
35. Increased strain on family "money" for medical/dental expenses.

*Item #22 was added to FILE for the AAL Study.

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Family Social Science
University of Minnesota
297 McNeal Hall
St. Paul, Minnesota 551(

36. Increased strain on family "money" for food, clothing, energy, home care.
37. Increased strain on family "money" for child(ren)'s education.
38. Delay in receiving child support or alimony payments.

V. Work-Family Transitions and Strains
39. A member changed to a new job/career.
40. A member lost or quit a job.
41. A member retired from work.
42. A member started or returned to work.
43. A member stopped working for extended period (e.g., laid off, leave of absence, strike).
44. Decrease in satisfaction with job/career.
45. A member had increased difficulty with people at work.
46. A member was promoted at work or given more responsibilities.
47. Family moved to a new home/apartment.
48. A child/adolescent member changed to a new school.

VI. Illness and Family "Care" Strains
49. Parent/spouse became seriously ill or injured.
50. Child became seriously ill or injured.
51. Close relative or friend of the family became seriously ill.
52. A member became physically disabled or chronically ill.
53. Increased difficulty in managing a chronically ill or disabled member.
54. Member or close relative was committed to an institution or nursing home.
55. Increased responsibility to provide direct care or financial help to husband's and/or wife's parent(s).
56. Experienced difficulty in arranging for satisfactory child care.

VII. Losses
57. A parent/spouse died.
58. A child member died.
59. Death of husband's or wife's parent or close relative.
60. Close friend of the family died.
61. Married son or daughter was separated or divorced.
62. A member "broke up" a relationsnip with a close friend.

VII. Transitions "In and Out"
63. A member was married.
64. Young adult member left home.
65. A young adult member began college (or post high school training)
66. A member moved back home or a new person moved into the household.
67. A parent/spouse started school (or training program) after being away from school for a long time.

IX. Family Legal Violations
68. A member went to jail or juvenile detention.
69. A member was picked up by police or arrested.
70. Physical or sexual abuse or violence in the home.
71. A member ran away from home.
72. A member dropped out of school or was suspended from school.

Your name _____ Subject No. _____

Address _____

_____

Date _____

Phone No. _____

Date of your birth _____

UNIVERSITY OF WASHINGTON
School of Nursing
INFANT & FAMILY FOCUS

LIFE EXPERIENCES SURVEY

The following is a list of common events in the lives of most people that require some adjustments in their lives. Please think back over the last year and decide whether each of these happened to you. If it did, please place a check mark by that item.

For each item that you check, we'd like to know whether the event was a positive one for you or a negative one. If it had no impact on you, circle the 0. If it was a negative impact, circle one of the negative numbers: -3 for extremely negative, -2 for moderately negative, and -1 for somewhat negative. If it had a positive impact, circle one of the positive numbers: +3 for extremely positive, +2 for moderately positive, and +1 for slightly positive.

Section I. Personal events	extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
___ a. Major change in sleeping habits (much more or much less sleep)	-3	-2	-1	0	+1	+2	+3
___ b. Major change in eating habits (much more or much less food intake)	-3	-2	-1	0	+1	+2	+3
___ c. Pregnancy	-3	-2	-1	0	+1	+2	+3
___ d. Abortion	-3	-2	-1	0	+1	+2	+3
___ e. Major personal illness or injury	-3	-2	-1	0	+1	+2	+3
___ f. Outstanding personal achievement	-3	-2	-1	0	+1	+2	+3

Subject No. _____

Date _____

	extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
Section II. Changes in the makeup of your household							
___ a. Change in residence	-3	-2	-1	0	+1	+2	+3
___ b. Major change in living conditions (new home, remodeling, etc.)	-3	-2	-1	0	+1	+2	+3
___ c. Detention in jail or other institution	-3	-2	-1	0	+1	+2	+3
___ d. Partner in jail or other institution	-3	-2	-1	0	+1	+2	+3
Section III. Financial Changes							
___ a. Major change in financial status (a lot better off or a lot worse off)	-3	-2	-1	0	+1	+2	+3
___ b. Foreclosure on mortgage or loan	-3	-2	-1	0	+1	+2	+3
___ c. Borrowing more than $10,000 (buying a home, business, etc.)	-3	-2	-1	0	+1	+2	+3
___ d. Borrowing less than $10,000 (buying a car, TV, school loan)	-3	-2	-1	0	+1	+2	+3
Section IV. Changes in Work							
___ a. New job	-3	-2	-1	0	+1	+2	+3
___ b. Changed work situation (different responsibilities, working conditions, hours, etc.)	-3	-2	-1	0	+1	+2	+3
___ c. Trouble with employer	-3	-2	-1	0	+1	+2	+3
___ d. Being fired from job	-3	-2	-1	0	+1	+2	+3
___ e. Retirement from work	-3	-2	-1	0	+1	+2	+3

Subject No. _____

Date _____

		extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
Section V. Changes in your partner and your relationship								
___ a.	Engagement	-3	-2	-1	0	+1	+2	+3
___ b.	Marriage	-3	-2	-1	0	+1	+2	+3
___ c.	Sexual difficulties	-3	-2	-1	0	+1	+2	+3
___ d.	Major change in number of arguments (many more or many fewer)	-3	-2	-1	0	+1	+2	+3
___ e.	Breaking up with boyfriend	-3	-2	-1	0	+1	+2	+3
___ f.	Separation from spouse (due to work, travel, etc.)	-3	-2	-1	0	+1	+2	+3
___ g.	Separation from spouse (due to conflict)	-3	-2	-1	0	+1	+2	+3
___ h.	Reconciliation with boyfriend	-3	-2	-1	0	+1	+2	+3
___ i.	Reconciliation with husband	-3	-2	-1	0	+1	+2	+3
___ j.	Change in husband/partner's work (new job, new hours, etc.)	-3	-2	-1	0	+1	+2	+3
___ k.	Divorce	-3	-2	-1	0	+1	+2	+3
___ l.	Death of husband	-3	-2	-1	0	+1	+2	+3
Section VI. Changes in your family								
___ a.	Major change in closeness of family	-3	-2	-1	0	+1	+2	+3
___ b.	Trouble with in-laws	-3	-2	-1	0	+1	+2	+3
___ c.	Gaining a new family member (through birth, adoption, moving in, etc.)	-3	-2	-1	0	+1	+2	+3
___ d.	Son or daughter leaving home (school, marriage, own apartment)	-3	-2	-1	0	+1	+2	+3

Subject No. _____

Date _____

Section VI. (continued)

	extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
___ e. Leaving home for the first time yourself	-3	-2	-1	0	+1	+2	+3
___ f. Serious illness or injury of close family member:							
___ Father	-3	-2	-1	0	+1	+2	+3
___ Mother	-3	-2	-1	0	+1	+2	+3
___ Sister	-3	-2	-1	0	+1	+2	+3
___ Brother	-3	-2	-1	0	+1	+2	+3
___ Grandfather	-3	-2	-1	0	+1	+2	+3
___ Grandmother	-3	-2	-1	0	+1	+2	+3
___ Husband	-3	-2	-1	0	+1	+2	+3
___ Other	-3	-2	-1	0	+1	+2	+3
___ g. Death of a family member:							
___ Mother	-3	-2	-1	0	+1	+2	+3
___ Father	-3	-2	-1	0	+1	+2	+3
___ Brother	-3	-2	-1	0	+1	+2	+3
___ Sister	-3	-2	-1	0	+1	+2	+3
___ Grandmother	-3	-2	-1	0	+1	+2	+3
___ Grandfather	-3	-2	-1	0	+1	+2	+3
___ Other (sepcify _____)	-3	-2	-1	0	+1	+2	+3

Subject No. _____

Date _____

	extremely negative	moderately negative	somewhat negative	no impact	slightly positive	moderately positive	extremely positive
Section VII. Changes in Friends and Social Events							
___ a. Serious injury or illness of close friend	-3	-2	-1	0	+1	+2	+3
___ b. Death of a close friend	-3	-2	-1	0	+1	+2	+3
___ c. Minor law violations (like traffic tickets)	-3	-2	-1	0	+1	+2	+3
___ d. Major change in usual type and/or amount of recreation	-3	-2	-1	0	+1	+2	+3
___ e. Major change in social activities (kind or amount of participation)	-3	-2	-1	0	+1	+2	+3
___ f. Major change in church activities (increased or decreased attendance)	-3	-2	-1	0	+1	+2	+3
___ g. End of formal schooling	-3	-2	-1	0	+1	+2	+3
___ h. Other experiences which have had an impact on your life. List and rate:							
_____	-3	-2	-1	0	+1	+2	+3
_____	-3	-2	-1	0	+1	+2	+3
_____	-3	-2	-1	0	+1	+2	+3

Appendix F.

Quality of the Caregiving Environment Scales

Home Observation for Measurement of the Environment
Nursing Child Assessment Feeding Scale
Nursing Child Assessment Teaching Scale

UNIVERSITY OF WASHINGTON
SCHOOL OF NURSING
NURSING CHILD ASSESSMENT TRAINING

HOME OBSERVATION FOR MEASUREMENT OF THE ENVIRONMENT
(BIRTH TO THREE YEARS)

[redacted] PERSON OBSERVED (CIRCLE)
MOTHER FATHER OTHER

[redacted] MAJOR CAREGIVER (CIRCLE)
YES NO

[redacted] MOTHER'S EDUCATION (CIRCLE)
6 YRS OR LESS 7-8-9-10-11-12-13-14
15-16-17-18-19-20+

[redacted] MARITAL STATUS (CIRCLE)
MARRIED NOT MARRIED

CHILD'S FIRST NAME _____
CHILD'S AGE (IN MONTHS) _____
CHILD'S SEX _____
CHILD'S RACE _____
PARITY _____
MOTHER'S AGE (AT BIRTH OF CHILD) _____

		YES	NO
I	EMOTIONAL AND VERBAL RESPONSIVITY OF MOTHER		
[redacted]	MOTHER SPONTANEOUSLY VOCALIZES TO CHILD AT LEAST TWICE DURING VISIT (EXCLUDING SCOLDING)		
[redacted]	MOTHER RESPONDS TO CHILD'S VOCALIZATIONS WITH VERBAL RESPONSE		
[redacted]	MOTHER TELLS CHILD THE NAME OF SOME OBJECT DURING VISIT OR SAYS NAME OF PERSON OR OBJECT IN A TEACHING STYLE		
[redacted]	MOTHER'S SPEECH IS DISTINCT CLEAR AND AUDIBLE		
[redacted]	MOTHER INITIATES VERBAL INTERCHANGES WITH OBSERVER—ASKS QUESTIONS MAKES SPONTANEOUS COMMENTS		
[redacted]	MOTHER EXPRESSES IDEAS FREELY AND EASILY AND USES STATEMENTS OF APPROPRIATE LENGTH FOR CONVERSATIONS (E.G. GIVES MORE THAN BRIEF ANSWERS)		
07	MOTHER PERMITS CHILD OCCASIONALLY TO ENGAGE IN "MESSY" TYPES OF PLAY		
[redacted]	MOTHER SPONTANEOUSLY PRAISES THE CHILD'S QUALITIES OR BEHAVIOR TWICE DURING VISIT		
[redacted]	WHEN SPEAKING OF OR TO CHILD MOTHER'S VOICE CONVEYS POSITIVE FEELING		
10	MOTHER CARESSES OR KISSES CHILD AT LEAST ONCE DURING VISIT		
[redacted]	MOTHER SHOWS SOME POSITIVE EMOTIONAL RESPONSES TO PRAISE OF CHILD OFFERED BY VISITOR		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
II	AVOIDANCE OF RESTRICTION AND PUNISHMENT		
[redacted]	MOTHER DOES NOT SHOUT AT CHILD DURING VISIT		
13	MOTHER DOES NOT EXPRESS OVERT ANNOYANCE WITH OR HOSTILITY TOWARD CHILD		
[redacted]	MOTHER NEITHER SLAPS NOR SPANKS CHILD DURING VISIT		
[redacted]	MOTHER REPORTS THAT NO MORE THAN ONE INSTANCE OF PHYSICAL PUNISHMENT OCCURRED DURING THE PAST WEEK		
[redacted]	MOTHER DOES NOT SCOLD OR DEROGATE CHILD DURING VISIT		
[redacted]	MOTHER DOES NOT INTERFERE WITH CHILD'S ACTIONS OR RESTRICT CHILD'S MOVEMENTS MORE THAN 3 TIMES DURING MY VISIT		
[redacted]	AT LEAST TEN BOOKS ARE PRESENT AND VISIBLE		
[redacted]	FAMILY HAS A PET		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
III	ORGANIZATION OF ENVIRONMENT		
[redacted]	WHEN MOTHER IS AWAY CARE IS PROVIDED BY ONE OF THREE REGULAR SUBSTITUTES		
21	SOMEONE TAKES CHILD INTO GROCERY STORE AT LEAST ONCE A WEEK		
[redacted]	CHILD GETS OUT OF HOUSE AT LEAST FOUR TIMES A WEEK		
23	CHILD IS TAKEN REGULARLY TO DOCTOR'S OFFICE OR CLINIC		
[redacted]	CHILD HAS A SPECIAL PLACE IN WHICH TO KEEP HIS TOYS AND "TREASURES"		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
[redacted]	ITEMS WHICH MAY REQUIRE DIRECT QUESTIONS		

		YES	NO
[redacted]	CHILD'S PLAY ENVIRONMENT APPEARS SAFE AND FREE OF HAZARDS		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
IV	PROVISION OF APPROPRIATE PLAY MATERIAL		
26	CHILD HAS SOME MUSCLE ACTIVITY TOYS OR EQUIPMENT		
27	CHILD HAS PUSH OR PULL TOY		
28	CHILD HAS STROLLER OR WALKER, KIDDIE CAR, SCOOTER OR TRICYCLE		
29	MOTHER PROVIDES TOYS OR INTERESTING ACTIVITIES FOR CHILD DURING INTERVIEW		
30	PROVIDES LEARNING EQUIPMENT APPROPRIATE TO AGE—CUDDLY TOY OR ROLE PLAYING TOYS		
31	PROVIDES LEARNING EQUIPMENT APPROPRIATE TO AGE—MOBILE, TABLE AND CHAIRS, HIGH CHAIR, PLAY PEN		
32	PROVIDES EYE-HAND COORDINATION TOYS—ITEMS TO GO IN AND OUT OF RECEPTACLE, FIT TOGETHER TOYS, BEADS		
33	PROVIDES EYE-HAND COORDINATION TOYS THAT PERMIT COMBINATIONS—STACKING OR NESTING TOYS, BLOCKS OR BUILDING TOYS		
34	PROVIDES TOYS FOR LITERATURE AND MUSIC		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
V	MATERNAL INVOLVEMENT WITH CHILD		
35	MOTHER TENDS TO KEEP CHILD WITHIN VISUAL RANGE AND TO LOOK AT HIM OFTEN		
36	MOTHER TALKS TO CHILD WHILE DOING HER WORK		
37	MOTHER CONSCIOUSLY ENCOURAGES DEVELOPMENTAL ADVANCE		
38	MOTHER INVESTS MATURING TOYS WITH VALUE VIA HER ATTENTION		
39	MOTHER STRUCTURES CHILD'S PLAY PERIODS		
40	MOTHER PROVIDES TOYS THAT CHALLENGE CHILD TO DEVELOP NEW SKILLS		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		
VI	OPPORTUNITIES FOR VARIETY IN DAILY STIMULATION		
41	FATHER PROVIDES SOME CARETAKING EVERY DAY		
42	MOTHER READS STORIES AT LEAST THREE TIMES WEEKLY		
43	CHILD EATS AT LEAST ONE MEAL PER DAY WITH MOTHER AND FATHER		
44	FAMILY VISITS OR RECEIVES VISITS FROM RELATIVES (APPROX. ONCE A MONTH)		
45	CHILD HAS THREE OR MORE BOOKS OF HIS OWN		
	SUBSCALE TOTAL (NO. OF YES ANSWERS)		

[illegible] TOTALS FOR EACH CATEGORY	
[illegible]OTIONAL AND VERBAL RESPONSIVITY OF MOTHER	
AVOIDANCE OF RESTRICTION AND PUNISHMENT	
[illegible]RGANIZATION OF ENVIRONMENT	
[illegible]OVISION OF APPROPRIATE PLAY MATERIAL	
MATERNAL INVOLVEMENT WITH CHILD	
[illegible]PORTUNITIES FOR VARIETY IN DAILY STIMULATION	
TOTAL SCORE (NO. OF YES ANSWERS)	

[illegible]AMPLES OF SELECTED QUESTIONS FOR THE HOME (BIRTH-3 YEARS)

SECTION I: EMOTIONAL AND VERBAL RESPONSIVITY OF MOTHER

ITEM 7 MESSINESS: "DOES HE SOMETIMES WANT TO PLAY IN HIS FOOD OR IN HIS BATH? OR DO YOU SOMETIMES LET HIM PLAY AND BE MESSY?"

SECTION II: AVOIDANCE OF RESTRICTION AND PUNISHMENT

ITEM 15 DISCIPLINE: "HOW DO YOU MANAGE HIS DISCIPLINE AT THIS AGE—WHAT WORKS THE BEST? IN GENERAL, DOES HE MIND PRETTY WELL OR DO YOU HAVE TO OCCASIONALLY SLAP HIS HANDS OR PHYSICALLY PUNISH HIM IN SOME WAY?"
IF YES: PROBE FOR NUMBER OF TIMES IN THE PAST WEEK

SECTION III: ORGANIZATION OF ENVIRONMENT

ITEM 20: "HOW ABOUT YOUR TIME OUTSIDE THE HOME AND AWAY FROM YOUR CHILD? DO YOU HAVE A REGULAR SITTER THAT YOU CAN COUNT ON OR DO YOU HAVE TO GET SOMEONE DIFFERENT EACH TIME?"
PROBE FOR: GROCERY STORE (ONCE A WEEK)
RELATIVES (MONTHLY)

ITEM 21 & 22: "HOW ABOUT HIS TIME OUT OF THE HOME? WHERE ARE SOME OF THE PLACES YOU TAKE HIM AND ABOUT HOW OFTEN DOES HE GET OUT OF THE HOUSE EACH WEEK?"
PROBE FOR: GROCERY STORE (ONCE PER WEEK)
RELATIVES (MONTHLY)

ITEM 24: "I'M INTERESTED IN SEEING SOME OF YOUR CHILD'S TOYS. WHERE HE KEEPS THEM AND SOME OF HIS FAVORITE THINGS TO PLAY WITH"

SECTION V: MATERNAL INVOLVEMENT WITH CHILD (CAN ASK WHILE LOOKING AT CHILD'S TOYS)

ITEM 36: "DO YOU SOMETIMES FIND YOURSELF MAKING CONVERSATION WITH HIM WHILE YOU'RE WORKING AROUND THE HOUSE OR IS HE USUALLY ASLEEP WHILE YOU'RE DOING YOUR HOUSEWORK?"

ITEM 37: "WHAT ARE SOME OF THE THINGS YOU'RE HELPING YOUR CHILD TO LEARN AT THIS AGE?"
PROBE FOR: DEVELOPMENT AGE APPROPRIATE THINGS - IE SELF FEEDING, WALKING, ETC

ITEM 38: "HOW DOES HE USUALLY GET STARTED PLAYING WITH A NEW TOY—DO YOU SHOW HIM HOW TO WORK IT AND TRY TO GET HIM INVOLVED WITH IT OR DOES HE USUALLY FIGURE IT OUT FOR HIMSELF?"

ITEM 39: "ON A DAY TO DAY BASIS, HOW DOES HE GET STARTED PLAYING WITH HIS TOYS? DO YOU SOMETIMES SIT AND PLAY WITH HIM OR DOES HE USUALLY GET STARTED BY HIMSELF AND PLAY ALONE?"

ITEM 40: "HOW DO YOU USUALLY DECIDE WHAT KINDS OF TOYS TO SELECT AND OFFER YOUR CHILD TO PLAY WITH AT THIS AGE—WHAT ARE SOME OF YOUR GUIDELINES?"
LISTEN FOR TOYS THAT WILL CHALLENGE CHILD TO DEVELOP NEW SKILLS

SECTION V: OPPORTUNITIES FOR VARIETY IN DAILY STIMULATION

ITEM 45 & 47: "HOW ABOUT BOOKS, DOES HE HAVE SOME OF HIS OWN YET?"
PROBE FOR: NUMBER OF HIS OWN BOOKS

"DOES HE SOMETIMES LIKE FOR YOU TO READ TO HIM?"
IF YES: "HOW MANY TIMES A WEEK DO YOU HAVE TIME TO DO THAT?"

ITEM 43: "WHAT DOES HE DO WHILE YOU AND YOUR HUSBAND EAT YOUR MEALS? DOES HE USUALLY EAT WITH YOU OR DOES HE EAT AT ANOTHER TIME?"

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NURSING CHILD ASSESSMENT TRAINING

FEEDING SCALE
(BIRTH TO ONE YEAR)

[redacted] FEEDING TAPE (CIRCLE)
YES NO

[redacted] OBSERVED IN INTERACTION (CIRCLE)
MOTHER FATHER OTHER

[redacted]OR CAREGIVER (CIRCLE)
[redacted]ES NO

[redacted]F FEEDING (CIRCLE)
[redacted]REAST BOTTLE SOLID

[redacted]GTH OF FEEDING (CIRCLE)
10 OR LESS 10-20 20-30 30 OR MORE

[redacted]G (CIRCLE)
[redacted]OME CLINIC OTHER

CHILD'S FIRST NAME _____
CHILD'S AGE (IN MONTHS) _____
CHILD'S SEX _____
CHILD'S RACE _____
PARITY _____
MOTHER'S EDUCATION (CIRCLE)
8 YRS OR LESS 7-8-9-10-11-12-13-14-15-16-17-18-19-20+
MARITAL STATUS (CIRCLE)
MARRIED NOT MARRIED
MOTHER'S AGE (AT BIRTH OF CHILD) _____

	YES	NO
SENSITIVITY TO CUES		
1 [redacted]ARENT POSITIONS CHILD SO THAT CHILD IS SAFE BUT CAN MOVE HIS [redacted]RMS		
2 PARENT POSITIONS CHILD SO THAT THE CHILD'S HEAD IS HIGHER THAN [redacted]		
3 [redacted]ARENT POSITIONS CHILD SO THAT TRUNK-TO-TRUNK CONTACT IS [redacted]AINTAINED DURING MORE THAN HALF OF THE BREAST OR BOTTLE [redacted]EEDING (50%)		
4 [redacted]ARENT POSITIONS CHILD SO THAT EYE-TO-EYE CONTACT IS POSSIBLE		
5 [redacted]ARENT'S FACE IS AT LEAST 7-8 INCHES OR MORE FROM THE CHILD'S [redacted]CE DURING FEEDING EXCEPT WHEN KISSING CARESSING HUGGING OR BURPING THE CHILD		
6 [redacted]ARENT SMILES VERBALIZES OR MAKES EYE CONTACT WITH CHILD [redacted]HEN CHILD IS IN OPEN-FACE-GAZE POSITION		
7 [redacted]ARENT COMMENTS VERBALLY ON CHILD'S HUNGER CUES PRIOR TO FEEDING		
8 [redacted]ARENT COMMENTS VERBALLY ON CHILD'S SATIATION CUES BEFORE [redacted]ERMINATING FEEDING		
9 PARENT VARIES THE INTENSITY OF VERBAL STIMULATION DURING FEEDING		
10 [redacted]ARENT VARIES INTENSITY OF ROCKING OR MOVING THE CHILD DURING [redacted]HE FEEDING		
11 PARENT VARIES THE INTENSITY OF TOUCH DURING THE FEEDING		
12 [redacted]ARENT ALLOWS PAUSES IN FEEDING WHEN THE CHILD INDICATES BY [redacted]RY FACE HALT HAND BACK ARCHING PULLING AWAY PUSHING FOOD [redacted]AY TRAY POUNDING TURNING HEAD SHAKING HEAD NO OR SAYING [redacted]NO OR FALLING ASLEEP OR WHEN CHILD'S IN PAUSE PHASE OF THE BURST-PAUSE SEQUENCE OF SUCKING (75% OF THE TIME)		
13 [redacted]ARENT SLOWS PACE OF FEEDING OR PAUSES WHEN CHILD AVERTS [redacted]GAZE PLACES HAND TO EAR HAND TO MOUTH HAND BEHIND HEAD [redacted]HAND BACK OF NECK HANDS OVER STOMACH YAWNS RUBS EYE OR [redacted]DISPLAYS FEE" MOVEMENT (75% OF THE TIME		
14 [redacted]ARENT TERMINATES THE FEEDING WHEN THE CHILD TURNS HEAD [redacted]FALLS ASLEEP COMPRESSES LIPS PUSHES FOOD AWAY SHAKES HEAD [redacted]NO OR SAYS NO ONCE OR MORE OR AFTER OTHER METHODS [redacted]REPOSITIONING BURPING OR WAITING) HAVE PROVED UNSUCCESSFUL		
15 PARENT DOES NOT INTERRUPT CHILD'S SUCKING OR CHEWING BY [redacted]REMOVING THE NIPPLE JIGGLING THE NIPPLE OR OFFERING THE CHILD [redacted]MORE OR OTHER KINDS OF FOOD WHILE CHILD IS EATING		
16 [redacted]PARENT DOES NOT OFFER FOOD WHEN THE CHILD LOOKS AWAY LOOKS [redacted]DOWN TURNS AWAY OR TURNS AROUND		
[redacted] SUBSCALE TOTAL (NO OF YES ANSWERS		
RESPONSE TO DISTRESS (INDICATE IN BOX WHETHER OCCURRED OR NOT IF NO DISTRESS MARK EACH BOX YES)		
[redacted]CHILD SHOWS DISTRESS DURING THE FEEDING DOES THE PARENT		
[redacted] STOP OR START FEEDING IN RESPONSE TO THE CHILD'S DISTRESS		
18 CHANGE THE CHILD'S POSITION IN RESPONSE TO CHILD'S DISTRESS		
[redacted] MAKE POSITIVE OR SYMPATHETIC VERBALIZATION IN RESPONSE TO CHILD'S DISTRESS		
20 CHANGES VOICE VOLUME TO SOFTER OR HIGHER PITCH IN RESPONSE TO CHILD'S DISTRESS		
[redacted] MAKES SOOTHING NON-VERBAL EFFORTS IN RESPONSE TO CHILD'S DISTRESS		
22 DIVERTS CHILD'S ATTENTION BY PLAYING GAMES INTRODUCING A TOY OR MAKING FACES IN RESPONSE TO CHILD'S DISTRESS		
[redacted] PARENT DOES NOT MAKE NEGATIVE VERBAL RESPONSE IN RESPONSE TO CHILD'S DISTRESS		
[redacted] PARENT DOES NOT MAKE NEGATIVE COMMENTS TO HOME VISITOR ABOUT CHILD IN RESPONSE TO CHILD'S DISTRESS		

[redacted]NEED ONLY OCCUR ONCE TO SCORE "NO"

	YES	NO
25 PARENT DOES NOT YELL AT THE CHILD IN RESPONSE TO HIS DISTRESS		
26 PARENT DOES NOT USE ABRUPT MOVEMENTS OR ROUGH HANDLING IN RESPONSE TO CHILD'S DISTRESS		
27 PARENT DOES NOT SLAP HIT OR SPANK CHILD IN RESPONSE TO DISTRESS		
SUBSCALE TOTAL (NO OF YES ANSWERS)		
III SOCIAL-EMOTIONAL GROWTH FOSTERING		
28 PARENT PAYS MORE ATTENTION TO CHILD DURING FEEDING THAN TO OTHER PEOPLE OR THINGS IN ENVIRONMENT		
29 PARENT IS IN EN FACE POSITION FOR MORE THAN HALF OF THE FEEDING (50%)		
30 PARENT SUCCEEDS IN MAKING EYE CONTACT WITH CHILD ONCE DURING FEEDING		
31 PARENT'S FACIAL EXPRESSION CHANGES AT LEAST TWICE DURING FEEDING		
32 PARENT ENGAGES IN SOCIAL FORMS OF INTERACTION (PLAYS GAMES WITH CHILD) AT LEAST ONCE DURING THE FEEDING		
33 PARENT USES POSITIVE STATEMENTS IN TALKING TO CHILD DURING THE FEEDING		
34 PARENT PRAISES CHILD OR SOME QUALITY OF THE CHILD'S BEHAVIOR DURING THE FEEDING		
35 PARENT HUMS CROONS SINGS OR CHANGES THE PITCH OF HIS HER VOICE DURING THE FEEDING		
36 PARENT LAUGHS OR SMILES DURING THE FEEDING		
37 PARENT USES GENTLE FORMS OF TOUCHING DURING THE FEEDING		
38 PARENT SMILES VERBALIZES OR TOUCHES CHILD WITHIN 5 SECONDS OF CHILD SMILING OR VOCALIZING AT PARENT		
39 PARENT DOES NOT COMPRESS LIPS GRIMACE OR FROWN WHEN MAKING EYE CONTACT WITH CHILD		
40 PARENT DOES NOT SLAP HIT SHAKE OR GRAB CHILD OR CHILD'S EXTREMITIES DURING THE FEEDING		
41 PARENT DOES NOT MAKE NEGATIVE OR UNCOMPLIMENTARY REMARKS TO THE CHILD OR HOME VISITOR ABOUT THE CHILD OR CHILD'S BEHAVIOR		
SUBSCALE TOTAL (NO OF YES ANSWERS		
IV COGNITIVE GROWTH FOSTERING		
42 PARENT PROVIDES CHILD WITH OBJECTS FINGER FOODS TOYS AND OR UTENSILS		
43 PARENT ENCOURAGES AND/OR ALLOWS THE CHILD TO EXPLORE THE BREAST BOTTLE FOOD CUP BOWL OR THE PARENT DURING FEEDING		
44 PARENT TALKS TO THE CHILD USING TWO WORDS AT LEAST THREE TIMES DURING THE FEEDING		
45 PARENT VERBALLY DESCRIBES SOME ASPECT OF THE FOOD OR FEEDING SITUATION TO CHILD DURING FEEDING		
46 PARENT TALKS TO CHILD ABOUT THINGS OTHER THAN FOOD EATING OR THINGS RELATED TO THE FEEDING		
47 PARENT USES STATEMENTS THAT DESCRIBE ASK QUESTIONS OR EXPLAINS CONSEQUENCES OF BEHAVIOR MORE THAN COMMANDS IN TALKING TO THE CHILD		
48 PARENT VERBALIZES TO CHILD WITHIN FIVE SECONDS AFTER CHILD HAS VOCALIZED		
49 PARENT VERBALIZES TO CHILD WITHIN FIVE SECONDS AFTER CHILD'S MOVEMENT OF ARMS LEGS HANDS HEAD TRUNK		
50 PARENT DOES NOT TALK BABY TALK		
SUBSCALE TOTAL (NO OF YES ANSWERS		

	YES	NO
...RITY OF CUES CHILD SIGNALS READINESS TO EAT		
92 CHILD DISPLAYS A BUILD-UP OF TENSION AT THE BEGINNING OF FEEDING		
CHILD DEMONSTRATES A DECREASE IN TENSION WITHIN A FEW MINUTES AFTER FEEDING HAS BEGUN		
94 CHILD HAS PERIODS OF ALERTNESS DURING THE FEEDING		
CHILD DISPLAYS AT LEAST TWO DIFFERENT EMOTIONS DURING THE FEEDING		
... CHILD HAS PERIODS OF ACTIVITY AND INACTIVITY DURING THE FEEDING		
CHILD'S MOVEMENTS ARE SMOOTH AND COORDINATED DURING THE FEEDING		
CHILD'S ARM AND LEG MOVEMENTS ARE GENERALLY DIRECTED TOWARD PARENT DURING FEEDING (NOT DIFFUSE)		
CHILD MAKES CONTACT WITH PARENT'S FACE OR EYES AT LEAST ONCE DURING FEEDING		
CHILD VOCALIZES DURING FEEDING		
CHILD SMILES OR LAUGHS DURING FEEDING		
CHILD AVERTS GAZE LOOKS DOWN OR TURNS AWAY DURING FEEDING		
CHILD ACTIVELY RESISTS FOOD OFFERED		
84 CHILD DEMONSTRATES SATISFACTION AT END OF FEEDING THROUGH SLEEP FACIAL EXPRESSION DECREASED MUSCLE TONE ARMS EXTENDED ALONG SIDE VOCALIZATIONS OR CHANGE IN ACTIVITY LEVEL OR MOOD		
85 CHILD DOES NOT HAVE MORE THAN TWO RAPID STATE CHANGES DURING FEEDING		
SUBSCALE TOTAL (NO OF YES ANSWERS		
...SPONSIVENESS TO PARENT CHILD RESPONDS TO FEEDING ATTEMPTS BY PARENT DURING FEEDING		
87 CHILD RESPONDS TO GAMES SOCIAL PLAY OR SOCIAL CUES OF PARENT DURING FEEDING		
CHILD LOOKS IN THE DIRECTION OF THE PARENT'S FACE AFTER PARENT HAS ATTEMPTED TO ALERT THE CHILD VERBALLY OR NON-VERBALLY DURING FEEDING		
CHILD VOCALIZES TO PARENT DURING FEEDING		
CHILD VOCALIZES OR SMILES WITHIN 5 SECONDS OF PARENT'S VOCALIZATION		
CHILD SMILES AT PARENT DURING FEEDING		
CHILD EXPLORES PARENT OR REACHES OUT TO TOUCH PARENT DURING FEEDING		
CHILD SHOWS A CHANGE IN LEVEL OF MOTOR ACTIVITY WITHIN 5 SECONDS OF BEING HANDLED OR REPOSITIONED BY PARENT		
76 CHILD SHOWS POTENT NEGATIVE CUES DURING LAST HALF OF FEEDING		
CHILD SHOWS POTENT NEGATIVE CUES WITHIN 5 SECONDS AFTER PARENT MOVES CLOSER THAN 7 TO 8 INCHES FROM CHILD'S FACE		
78 CHILD DOES NOT TURN AWAY OR AVERT GAZE FROM PARENT DURING FIRST HALF OF FEEDING		
SUBSCALE TOTAL (NO OF YES ANSWERS)		

ENTER TOTALS FOR EACH CATEGORY	
SENSITIVITY TO CUES	
RESPONSE TO DISTRESS	
SOCIAL-EMOTIONAL GROWTH FOSTERING	
COGNITIVE GROWTH FOSTERING	
CLARITY OF CUES	
RESPONSIVENESS TO PARENT	
TOTAL (NO OF YES ANSWERS)	

HOME VISIT QUESTIONS

1 WOULD YOU SAY THIS WAS A TYPICAL FEEDING?
A YES B NO
IF NO WHY NOT?

2 WERE YOU UNCOMFORTABLE DURING ANY PART OF THE FEEDING DUE TO MY PRESENCE?
A YES B NO
IF YES WHY?

3 DO YOU HAVE ANY CONCERNS ABOUT THE FEEDING OR YOUR CHILD'S EATING?
A YES NO
IF YES SPECIFY

4 OBSERVER'S COMMENTS

UNIVERSITY OF WASHINGTON
SCHOOL OF NURSING
NURSING CHILD ASSESSMENT TRAINING

TEACHING SCALE
(BIRTH TO THREE YEARS)

CHILD'S FIRST NAME _____

CHILD'S AGE (IN MONTHS) _____

CHILD'S SEX _____

CHILD'S RACE _____

PARITY _____

MOTHER'S EDUCATION (CIRCLE)
8 YRS OR LESS 7-8-9-10-11-12-13-14
15-16-17-18-19-20+

MARITAL STATUS (CIRCLE)
MARRIED NOT MARRIED

MOTHER'S AGE (AT BIRTH OF CHILD) _____

[redacted] ON OBSERVED IN INTERACTION (CIRCLE)
MOTHER FATHER OTHER

MAJOR CAREGIVER (CIRCLE)
YES NO

[redacted] CHING TASK _____

[redacted] GTH OF TEACHING (CIRCLE) MIN
1 OR LESS 2 3 4 5 6 OR MORE

[redacted] TTING (CIRCLE)
HOME CLINIC OTHER

	YES	NO
[redacted] SITIVITY TO CUES		
1 PARENT POSITIONS CHILD SO CHILD IS SAFELY SUPPORTED		
[redacted] PARENT POSITIONS CHILD SO THAT CHILD CAN REACH AND MANIPULATE MATERIALS		
3 PARENT GETS THE CHILD'S ATTENTION BEFORE BEGINNING THE TASK AT THE OUTSET OF THE TEACHING INTERACTION		
[redacted] IN NEARLY ALL CASES PARENT GIVES INSTRUCTIONS ONLY WHEN THE CHILD IS ATTENTIVE (80%)		
5 PARENT ALLOWS CHILD TO EXPLORE THE TASK MATERIALS FOR AT LEAST 5 SECONDS BEFORE GIVING THE FIRST TASK RELATED INSTRUCTION		
[redacted] PARENT POSITIONS CHILD SO THAT IT IS POSSIBLE FOR THEM TO HAVE EYE-TO-EYE CONTACT WITH ONE ANOTHER DURING THE TEACHING EPISODE		
[redacted] PARENT PAUSES WHEN CHILD INITIATES BEHAVIORS DURING THE TEACHING EPISODE		
8 PARENT PRAISES CHILD'S SUCCESSES OR PARTIAL SUCCESSES		
[redacted] PARENT ASKS FOR NO MORE THAN THREE PERFORMANCES WHEN CHILD IS SUCCESSFUL AT COMPLETING THE TASK		
10 PARENT CHANGES POSITION OF CHILD AND OR MATERIALS AFTER UNSUCCESSFUL ATTEMPT BY THE CHILD TO DO THE TASK		
[redacted] PARENT DOES NOT PHYSICALLY FORCE THE CHILD TO COMPLETE THE TASK		
[redacted] SUBSCALE TOTAL (NO OF YES ANSWERS)		
[redacted] RESPONSE TO DISTRESS (INDICATE WHETHER DISTRESS OCCURRED OR NOT)		
[redacted] STOPS THE TEACHING EPISODE		
[redacted] MAKES POSITIVE SYMPATHETIC OR SOOTHING VERBALIZATION		
14 CHANGES VOICE VOLUME TO SOFTER OR HIGHER PITCH (DOES NOT YELL)		
[redacted] REARRANGES THE CHILD'S POSITION AND OR TASK MATERIALS		
16 MAKES SOOTHING NON-VERBAL RESPONSE E.G. PAT TOUCH ROCK CARESS KISS		
[redacted] DIVERTS CHILD'S ATTENTION BY PLAYING GAMES INTRODUCES NEW TOY		
[redacted] DOES NOT MAKE NEGATIVE COMMENTS TO THE CHILD		
[redacted] DOES NOT YELL AT THE CHILD		
[redacted] DOES NOT USE ABRUPT MOVEMENTS OR ROUGH HANDLING		
[redacted] DOES NOT SLAP HIT OR SPANK		
22 DOES NOT MAKE NEGATIVE COMMENTS TO HOME VISITOR ABOUT THE CHILD		
[redacted] SUBSCALE TOTAL (NO OF YES ANSWERS)		
[redacted] SOCIAL-EMOTIONAL GROWTH FOSTERING		
[redacted] PARENT'S BODY POSTURE IS RELAXED DURING THE TEACHING EPISODE (AT LEAST HALF THE TIME)		
24 PARENT IS IN THE FACE-TO-FACE POSITION WITH THE CHILD DURING THE TEACHING INTERACTION (AT LEAST HALF THE TIME)		
[redacted] PARENT LAUGHS OR SMILES AT CHILD DURING THE TEACHING		
26 PARENT GENTLY PATS CARESSES STROKES HUGS OR KISSES CHILD DURING EPISODE		

	YES	NO
27 PARENT SMILES OR TOUCHES CHILD WITHIN 5 SECONDS WHEN CHILD SMILES OR VOCALIZES		
28 PARENT PRAISES CHILD'S EFFORTS OR BEHAVIORS BROADLY (IN GENERAL) AT LEAST ONCE DURING THE EPISODE		
29 PARENT MAKES CONSTRUCTIVE OR ENCOURAGING STATEMENT TO THE CHILD DURING THE TEACHING INTERACTION		
30 PARENT DOES NOT VOCALIZE TO THE CHILD AT THE SAME TIME THE CHILD IS VOCALIZING		
31 PARENT DOES NOT MAKE GENERAL NEGATIVE OR UNCOMPLIMENTARY REMARKS ABOUT THE CHILD		
32 PARENT DOES NOT YELL AT THE CHILD DURING THE EPISODE		
33 PARENT DOES NOT MAKE CRITICAL NEGATIVE COMMENTS ABOUT THE CHILD'S TASK PERFORMANCE		
SUBSCALE TOTAL (NO OF YES ANSWERS)		
IV COGNITIVE GROWTH FOSTERING		
34 PARENT PROVIDES AN ORGANIZED ENVIRONMENT WHICH IS FREE FROM DISTRACTIONS FROM ANIMATE SOURCES (SIBS PETS ETC)		
35 PARENT FOCUSES ATTENTION ON CHILD'S ATTENTION ON THE TASK DURING MOST OF THE TEACHING (80% OF THE TIME)		
36 AFTER PARENT GIVES INSTRUCTIONS AT LEAST 5 SECONDS IS ALLOWED FOR THE CHILD TO ATTEMPT THE TASK BEFORE PARENT INTERVENES AGAIN		
37 PARENT ALLOWS NON-TASK MANIPULATION OF THE TASK MATERIALS AFTER THE ORIGINAL PRESENTATION		
38 PARENT DESCRIBES PERCEPTUAL QUALITIES OF THE TASK MATERIALS TO THE CHILD		
39 PARENT USES AT LEAST TWO DIFFERENT SENTENCES OR PHRASES TO DESCRIBE THE TASK TO THE CHILD		
40 PARENT USES EXPLANATORY VERBAL STYLE MORE THAN IMPERATIVE STYLE IN TEACHING THE CHILD		
41 PARENT'S DIRECTIONS ARE STATED IN CLEAR UNAMBIGUOUS LANGUAGE (E.G. AMBIGUOUS = TURN REACH UNAMBIGUOUS = TURN THE KNOB TOWARD ME)		
42 PARENT USES BOTH VERBAL DESCRIPTION AND MODELING SIMULTANEOUSLY IN TEACHING ANY PART OF THE TASK		
43 PARENT ENCOURAGES AND OR ALLOWS THE CHILD TO PERFORM THE TASK BEFORE INTRUDING IN ON THE USE OF TASK MATERIALS		
44 PARENT VERBALLY PRAISES CHILD AFTER CHILD HAS PERFORMED BETTER OR MORE SUCCESSFULLY THAN THE LAST ATTEMPT		
45 PARENT SMILES AND OR NODS AFTER CHILD PERFORMS BETTER OR MORE SUCCESSFULLY THAN THE LAST ATTEMPT		
46 PARENT RESPONDS TO THE CHILD'S VOCALIZATIONS WITH VERBAL RESPONSE		
47 PARENT USES BOTH VERBAL AND NONVERBAL INSTRUCTIONS IN TEACHING THE CHILD		
48 PARENT USES TEACHING LOOPS IN INSTRUCTING CHILD (75% OF THE TIME)		
49 PARENT SIGNALS COMPLETION OF TASK TO CHILD VERBALLY OR NONVERBALLY		
50 PARENT SPENDS NOT MORE THAN 5 MINUTES AND NOT LESS THAN ONE MINUTE IN TEACHING THE CHILD THE TASK		
SUBSCALE TOTAL (NO OF YES ANSWERS)		

	YES	NO
...TY OF CUES		
...CHILD IS AWAKE		
...CHILD WIDENS EYES AND/OR SHOWS POSTURAL ATTENTION TO TASK SITUATION		
...CHILD CHANGES INTENSITY OR AMOUNT OF MOTOR ACTIVITY WHEN TASK MATERIAL IS PRESENTED		
...CHILD'S MOVEMENTS ARE CLEARLY DIRECTED TOWARD THE TASK MATERIALS OR AWAY FROM THE TASK OR TASK MATERIALS (NOT DIFFUSE)		
5 CHILD MAKES CLEARLY RECOGNIZABLE ARM MOVEMENTS DURING THE TEACHING EPISODE (CLAPPING, REACHING, WAVING, POUNDING, POINTING, PUSHING AWAY)		
6 CHILD VOCALIZES WHILE LOOKING AT TASK MATERIALS		
...CHILD SMILES OR LAUGHS DURING THE EPISODE		
...CHILD GRIMACES OR FROWNS DURING THE TEACHING EPISODE		
9 CHILD DISPLAYS POTENT DISENGAGEMENT CUES DURING THE TEACHING INTERACTION		
...CHILD DISPLAYS SUBTLE DISENGAGEMENT CUES DURING THE TEACHING INTERACTION		
SUBSCALE TOTAL (NO. OF YES ANSWERS)		
RESPONSIVENESS TO PARENT		
5 CHILD GAZES AT PARENT'S FACE OR TASK MATERIALS AFTER PARENT HAS SHOWN VERBAL OR NONVERBAL ALERTING BEHAVIOR		
52 CHILD ATTEMPTS TO ENGAGE PARENT IN EYE-TO-EYE CONTACT		
...THE CHILD LOOKS AT THE PARENT'S FACE OR EYES WHEN PARENT ATTEMPTS TO ESTABLISH EYE-TO-EYE CONTACT		
54 CHILD VOCALIZES OR BABBLES WITHIN 5 SECONDS AFTER PARENT'S VERBALIZATION		
...CHILD VOCALIZES OR BABBLES WITHIN 5 SECONDS AFTER PARENT'S GESTURES, TOUCHING OR CHANGING FACIAL EXPRESSION		
56 CHILD SMILES AT PARENT WITHIN 5 SECONDS AFTER PARENT'S VERBALIZATION		
...CHILD SMILES AT PARENT WITHIN 5 SECONDS AFTER PARENT'S GESTURE, TOUCH OR FACIAL EXPRESSION CHANGES		
...WHEN PARENT MOVES CLOSER THAN 8 INCHES FROM THE CHILD'S FACE—THE CHILD SHOWS SUBTLE AND OR POTENT DISENGAGEMENT CUES.		
69 CHILD SHOWS SUBTLE AND OR POTENT DISENGAGEMENT CUES WITHIN 5 SECONDS AFTER PARENT CHANGES FACIAL EXPRESSION OR BODY MOVEMENTS		
...CHILD SHOWS SUBTLE AND OR POTENT DISENGAGEMENT CUES WITHIN 5 SECONDS AFTER PARENT'S VERBALIZATION		
71 THE CHILD SHOWS SUBTLE AND/OR POTENT DISENGAGEMENT CUES WHEN PARENT ATTEMPTS TO INTRUDE PHYSICALLY IN THE CHILD'S USE OF THE TASK MATERIAL		
72 CHILD PHYSICALLY RESISTS OR RESPONDS AGGRESSIVELY WHEN PARENT ATTEMPTS TO INTRUDE PHYSICALLY IN CHILD'S USE OF THE TASK MATERIAL		
...THE CHILD STOPS DISPLAYING DISTRESS CUES WITHIN 15 SECONDS AFTER PARENT'S SOOTHING ATTEMPTS		
SUBSCALE TOTAL (NO. OF YES ANSWERS)		

ENTER TOTALS FOR EACH CATEGORY	
SENSITIVITY TO CUES	
RESPONSE TO DISTRESS	
SOCIAL-EMOTIONAL GROWTH FOSTERING	
COGNITIVE GROWTH FOSTERING	
CLARITY OF CUES	
RESPONSIVENESS TO PARENT	
TOTAL (NO. OF YES ANSWERS)	

1 WERE YOU UNCOMFORTABLE DURING ANY PART OF THE TEACHING DUE TO MY PRESENCE?

A YES B NO

IF YES WHY?

2 OBSERVER'S COMMENTS

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Appendix G.

References

Affleck, G., Tennen, H., Allen, D.A., & Gershman, K. (1986). Perceived social support and maternal adaptation during the transition from hospital to home care of high risk infants. Infant Mental Health Journal, 7, 6-18.

Bailey, D. (In press). Management in early intervention. Journal of the Division for Early Childhood.

Bailey, D. (1987). Collaborative goal setting with families: Resolving differences in values and priorities for services. Topics in Early Childhood Special Education, 7, 59-71.

Bailey, D. and Simeonsson, R. (1985) Survey of family needs. Chapel Hill: University of North Carolina.

Barnard, K.B. (1978). Nursing child assessment feeding scale. Seattle: University of Washington School of Nursing.

Barnard, K.B. (1978). Nursing child assessment teaching scale. Seattle: University of Washington School of Nursing.

Barnard, K.B. (1985). Life experiences survey. Seattle: University of Washington.

Barnard, K.E., & Bee, H.L. (1985). The assessment of parent-infant interaction by observation of feeding and teaching. Unpublished paper, University of Washington, School of Nursing and the Child Development and Mental Retardation Center, Seattle.

Bee, H.L., Barnard, K.E., Eyres, S.J., Gray, C.A., Hammond, M.A., Spietz, A.L., Snyder, C., & Clark, B. (1982). Prediction of IQ and language skill from perinatal status, child performance, family characteristics, and mother-infant interaction. Child Development, 53, 1134-1156.

Belsky, J. (1985). Experimenting with the family in the newborn period. Child Development, 56, 407-414.

Belsky, J. and Steinberg, L.D. (1979). The effects of day care: A critical review. Annual Progress in Child Psychiatry and Child Development, 576-611.

Bennett, F.C. (1987). The effectiveness of early intervention of infants at increased biologic risk. In M.J. Guralnick and Forrest C. Bennett (Eds.), The effectiveness of early intervention for at risk and handicapped children (pp.33-78). Orlando: Academic Press, Inc.

Berrueter-Clement, J. (1984). Changed lives. The effects of the Perry Preschool Program on youths through age 19. Monographs of the High/Scope Educational Research Foundation, 8.

Bradley, R., & Caldwell, B. (1976). The relationship of infant's home environment to mental test performance at 54 months: A follow up study. Child Development, 47, 1172-1174.

Bristol, M.M. (1983). Carolina Parent Support Scale. Chapel Hill: University of North Carolina.

Bristol, M.M. and Gallagher, J.J. (1982). A family focus for intervention. In C.T. Ramey & P.L. Trohanis (Eds.). Finding and educating high risk and handicapped infants. Baltimore: University Park Press.

Broman, S. (1979). Perinatal anoxia and cognitive development in early childhood. In T.M. Field, M. Sostek, S. Goldberg, and H. Shuman (Eds.), Infants born at risk. New York: Spectrum Publications.

Broman, S., Bien, E., and Shaughnessy, P. (1985). Low achieving children: The first seven years. Hillsdale, NJ: Erlbaum.

Bronfenbrenner, V. (1975). Is early intervention effective? In B. Friedlander, G. Stenit, and G. Kirk (Eds.) Exceptional infant: Vol. 3. Assessment and intervention. New York: Brunner/Mazel.

Bryant, D.M. & Ramey, C.T. (1987). An analysis of the effectiveness of early intervention programs for environmentally at risk children. In M.J. Guralnick and Forrest C. Bennett (Eds.), The effectiveness of early intervention for at risk and handicapped children (pp.33-78). Orlando: Academic Press, Inc.

Campbell, D.T. & Stanley, J.C. (1966). Experimental and quasi-experimental designs for research. Chicago: Rand McNally.

Carolina Institute for Research in Early Education for the Handicapped (1985). Frank Porter Graham Child Development Center, University of North Carolina (Chapel Hill).

Chandler, L.K., Fowler, S.A., Lubeck, R.C. (1986). Assessing family needs: The first step in providing family focused intervention. Diagnostique, 11, 233-245.

Cohen, S. & Syme, S. (1985). Social support and health. New York: Academic Press.

Corah, N., Anthony, E., Painter, P., Stern, J., & Thurston, D. (1965). Effects of perinatal anoxia after seven years. Psychological Monographs, 79 (3, Whole No. 596).

Crnic, K.A., Greenberg, M.T., and Slough, M.M. (1986). Early Stress and social support influences on mothers' and high risk infants' functioning in late infancy. Infant Mental Health Journal, 7, 19-48.

Crockenberg, S.B. (1986). Professional support for adolescent mothers: Who gives it, how adolescent mothers evaluate it, what they would prefer. Infant Mental Health Journal. 7, 49-58.

Darling, R.B. (1983). Parent-professional interaction: The roots of misunderstanding. In M. Seligman (Ed.), The family with a handicapped child. Miami: Grune and Stratton, Inc.

Denhoff, E., Hainsworth, P.K., & Hainsworth, M.L. (1972). The child at risk for learning disorder. Clinical Pediatrics, 11, 164-170.

Dunst, C. (1988). Supporting and strengthening families: New visions, new directions. Family Resource Coalition Report, 7, 2, 4-6.

Dunst, C.J. & Trivette, C.M. (In press). An enablement and empowerment perspective of case management. Topics in Early Childhood Special Education.

Dunst, C.J. & Trivette, C.M. (1985). A guide to measures of social support and family behaviors. Chapel Hill: Technical Assistance Development System, Monograph Number 1.

Dunst, C.J., Trivette, C.M., and Deal, A.G. (1987). Enabling and empowering families: Principles and guidelines for practice. Cambridge: Brookline Books.

Dunst, C.J., Trivette, C.M., McWilliam, R.A., & Galant, K. (1987). Toward experimental evaluation of the family, infant, & preschool program. In H. Weiss and F. Jacobs (Eds.), Evaluating family programs. New York: Aldine Publishing Company.

Dunst, C., Vance, S. & Cooper, C. (1986). A social systems perspective of adolescent pregnancy: Determinants of parent and parent-child behavior. Infant Mental Health Journal, 7, 34-48.

Epstein, N.B., Bishop, D.S., & Baldwin, L.M. (1982). McMaster model of family functioning: A view of the normal family. In F. Walsh (Ed.) Normal family processes. New York: Guilford Press.

Friedman, D.H. & Friedman, S. (1982). Day care as a setting for intervention in family systems. Social Casework: The Journal for Contemporary Social Work, 291-295.

Friedman, S., Reiss, J. & Pierce, P. (1988). Focus and functions of family centered case management. A working paper. Institute for Child Health Policy. Gainesville: Florida State University.

Friedrich, W.N., Greenberg, M.T., and Crnic, K. (1983). A short form of the questionnaire on resources and stress. American Journal of Mental Deficiency, 88, 41-48.

Field, T.M. (1982). Infants born at risk: early compensatory experiences. In L.A. Bond & J.M. Joffe (Eds.) Facilitating infant and early childhood development. Hanover: University Press of New England.

Garbarino, J. (1982). Children and families in the social environment. Hawthorne, N.Y.: Aldine Publishing Co.

Garbarino, J. (1986). The abuse and neglect of special children: An introduction to the issues. In J. Garbarino and K. Authier (Eds.), Safe environments for handicapped children. New York: Aldine Publishing Co.

Garber, H.L. (1988). The Milwaukee Project. Preventing mental retardation in children at risk. Washington, D.C.: American Association on Mental Retardation.

Garland, C. (1981). Early intervention for children with special needs and their families: Findings and recommendations (WESTAR Series Paper No. 11). Seattle, WA: University of Washington.

Garland, C., Woodruff, G. & Buck, D. (1988). Case management. Division for Early Childhood, Council for Exceptional Children White Paper.

Guralnick, M. and Bennett, F. (1987). The effectiveness of early intervention for at risk and handicapped children. Orlando: Academic Press, Inc.

Guralnick, M.J. & Bricker, D. (1987). The effectiveness of early intervention for children with cognitive and general developmental delays. In M.J. Guralnick and Forrest C. Bennett (Eds.), The effectiveness of early intervention for at risk and handicapped children (pp.33-78). Orlando: Academic Press, Inc.

Harbin, G.L. (1988). Issues in the assessment of infants and toddlers with handicaps. Chapel Hill: University of North Carolina.

Hanson, M.J. & Schwarz, R.H. (1978). Results of a longitudinal intervention program for Down Syndrome infants and their families. Education & Training of the Mentally Retarded, 13, 403-407.

Herzog, L.P., Cherniss, D.S. & Menzel, B.J. (1986). Issues in engaging high-risk adolescent mothers in supportive work. Infant Mental Health Journal, 7, 59-68.

Hobbs, N. (1979). Helping disturbed children: Psychological and ecological strategies, II: Project Re-ed, twenty years later. Center for the Study of Families and Children, Vanderbilt Institute for Public Policy Studies, Vanderbilt University.

Hobbs, N., Dokecki, P.R., Hoover-Dempsey, K., Moroney, R.M., Shayne, M.W., and Weeks, K.H. (1984). Strengthening families. San Francisco: Jossey-Bass, Inc.

Imber-Black, E. (1988). Families and larger systems: A family therapist's guide through the labyrinth. New York: Guilford Press, Inc.

Iris, M.A. (1988). The parent/professional relationship: Complex connections, intricate bonds. Family Resource Coalition Report, 7, 9.

Jeppson, E.S. (1988). Parents take priority in family-centered care. Family Resource Coalition Report, 7, 1-2.

Kochanek, T.T. (1980). Early detection programs for preschool handicapped children: Some procedural recommendations. Journal of Special Education, 14, 347-353.

Kochanek, T.T. (1987). Preschool early detection and infant classification technique and service. Handicapped Children's Early Education Project (Grant No. G008730278), U.S. Department of Education. Providence: Rhode Island College.

Kochanek, T.T., Kabacoff, R.I., & Lipsitt, L.P. (1987). Early detection of handicapping conditions in infancy and early childhood: Toward a multivariate model. Journal of Applied Developmental Psychology, 8, 411-420.

Kysela, G., Hillyard, A., McDonald, L., and Ahlsten-Taylor, J. (1981). Early intervention: Design and evaluation. In R.L. Schiefelbusch & D.D. Bricker (Eds.) Language intervention series: Vol. 6. Early Language: acquisition and intervention. Baltimore: University Park Press.

Lazar, I., Darlington, R. Moray, H., Royce, J., & Snipper, A. (1982). Lasting effects of early education: A report from the Consortium for Longitudinal Studies. Monographs of the Society for Research in Child Development, 47 (2-3, Serial No. 195).

Levine, M.D., Palfrey, J.S., Lamb, G.A., Weisberg, H.H., & Bryk, A.S. (1977). Infants in a public school system: The indicators of early health and educational need. Pediatrics, 60, 579-587.

Lipsitt, L.P. (1986). Learning in infancy: Cognitive development in babies. Journal of Pediatrics, 109, 172-182.

Little, W. On the influence of abnormal parturition, difficult labors, premature birth, and asphyxia neonatorum, on the medical and physical condition of the child, especially in relation to deformities. Transactions of the Obstetrical Society of London, 1861, 3, 293.

May, J. (1988). Special needs children, special needs fathers. Family Resource Coalition Report, 7, 10.

McGoldrick, M., Pearce, J.K. & Giordano, J. (1982). Ethnicity and family therapy. New York: Guilford Press, Inc.

McGonigel, M.J. & Garland, C.W. (1988). The individualized family service plan and the early intervention team: Team and family issues and recommended practices. Infants and Young Children, 1, 10-21.

McNulty, B.A. (1983). Effectiveness of early special education for handicapped children. Report commissioned by the Colorado General Assembly, Denver, CO.

Meier, J. (1985). Assault against children. San Diego: College Hill Press.

Meisels, S.J. & Wasik, B.A. (1988). Who should be served? Identifying children in need of early intervention. In S.J. Meisels & J.P. Shonkoff (Eds.), Handbook of Early Childhood Intervention. New York: Cambridge University Press.

Mitchell, S.K., Bee, H.L., Hammond, M.A., & Barnard, K. E. (1985). Prediction of school and behavior problems in children followed from birth to age eight. In W.K. Frankenburg, R.N. Emde, & J.W. Sullivan (Eds.), Early Identification of children at risk. New York: Plenum.

Mitchell, S.K., Magyary, D., Barnard, K.E., Sumner, G.A., & Booth, C.L. (1985). A comparison of home based prevention programs for families of newborns. Unpublished paper, University of Washington, School of Nursing and the Child Development and Mental Retardation Center, Seattle.

Moos, R.H. & Moos, B.S. (1981). Family environment scale manual. Palo Alto: Consulting Psychologists Press.

Nichols, P.L., & Chen, T. (1981). Minimal brain dysfunction: A prospective study. Hillsdale, NJ: Erlbaum.

O'Connor, G. (1983). Social support of mentally retarded persons. Mental Retardation, 21, 187-186.

O'Grady, D. and Metz, R. (1987). Resilience in children at high risk for psychological disorder. Journal of Pediatric Psychology, 12, 3-23.

Olson, D.H., McCubbin, H.I., Barnes, H., Larsen, A., Muxen, M., and Wilson, M. (1982). Family inventories. St. Paul: University of Minnesota.

Parmelee, A., & Michaelis, R. (1971). Neurological examination of the newborn. In J. Hellmuth (Ed.), Exceptional infants (Vol. 2). New York: Brunner/Mazel.

Patterson, J.M. & McCubbin, H.I. (1983). Chronic illness: Family stress and coping. In C.R. Figley and H.I. McCubbin (Eds.). Stress and the family: Vol. II. Coping with catastrophe. New York: Brunner-Mazel.

Pfeffer, C., Solomon, G., Plutchik, R., Mizruchi, M., and Weiner, A. (1985). Variables that predict assaultiveness in child psychiatric patients. Journal of the American Academy of Child Psychiatry, 26, 775-780.

Rynders, J.E. and Horrobin, J.M. (1980). Educational provisions for young children with Down Syndrome. In J. Gottlieb (Ed.) Educating mentally retarded persons in the mainstream. Baltimore: University Park Press.

Sameroff, A.J. & Chandler, M. (1975). Reproductive risk and the continuum of caretaking casualty. In F.D. Horowitz (Ed.), Review of Child Development Research (Vol. 4). Chicago: University of Chicago Press.

Sameroff, A.J., Seifer, R., Barocas, R., Zax, M., & Greenspan, S. (1987). Intelligence quotient scores of 4 year old children: Social environmental risk factors. Pediatrics, 79, 343-350.

Sarason, I.G., Johnson, J.H., and Siegal, J.M. (1978). Assessing the impact of life changes: Development of the life experiences survey. Journal of Consulting and Clinical Psychology, 46, 932-946.

Schweinhart, L.J. & Weikart, D.B. (1980). Young children grow up: The effects of the Perry Preschool Program on youths through age 15. Ypsilanti, MI: High/Scope Educational Research Foundation.

Scott, K.G. & Masi, W. (1979). The outcome from and utility of registers of risk. In T.M. Field (Ed.) Infants born at risk. New York: Spectrum Publications.

Shonkoff, J. & Hauser-Cram, P. (1987). Early intervention for disabled infants and their families: A quantitative analysis. Pediatrics, 80, 650-658.

Siegel, L.L. (1985). A risk index to predict learning problems in preterm and full term children. In W.K. Frankenburg, R.N. Emde, & J.W. Sullivan (Eds.), Early identification of children at risk. New York: Plenum.

Sigman, M., & Parmelee, A. (1979). Longitudinal evaluation of the pre-term infant. In T.M. Field, M. Sostek, S. Goldberg, & H.H. Shuman (Eds.), Infants born at risk. New York: Spectrum Publications.

Salvia, J. & Ysseldyke, J. (1985). Assessment in special and remedial education. Boston: Houghton Mifflin Co.

Simeonsson, R.J., Cooper, D.H. and Scheiner, A.P. (1982). A review and analysis of the effectiveness of early intervention programs. Pediatrics, 69, 635-641.

Susser, M., Hauser, W.A., & Kelly, J.L. (1985). Quantitative estimates of prenatal and perinatal risk factors for perinatal mortality, cerebral palsy, mental retardation, and epilepsy. In J.M. Friedman (Ed.) Prenatal and perinatal factors associated with brain disorders. Washington, D.C.: National Institutes of Health, Pub. No. 85-1149.

Trivette, C.M. & Dunst, C.J. (1986). Influences of social support on mentally retarded children and their families. Paper presented at the second annual Parent Symposium, Philadelphia, PA.

Trivette, C.M. and Dunst, C.J. (1987). Caregiver styles of interaction: Child, parent, family, and extra family influences. Unpublished manuscript. Family, Infant, and Preschool Program, Western Carolina Center, Morganton, NC.

Tyler, F.B., Pargament, K.J. & Gaty, M. (1983). The resource collaborator role, American Psychologist, 38, 388-398.

University of Connecticut, Pediatric Research and Training Center's Workbook #2 (1988). An introduction to building teams in early childhood special education. University of Connecticut Health Center, the Exchange, Farmington, CT.

University of Connecticut, Pediatric Research and Training Center's Workbook #11 (1988). An introduction to Individual Family Service Plans in early childhood special education. University of Connecticut Health Center, the Exchange, Farmington, CT.

Weick, A. and Pope, L. (1988). Knowing what's best: A new look at self-determination. Social Casework: The Journal of Contemporary Social Work, 10-17.

Werner, E.E., Bierman, J.M., & French, F.E. (1971). The children of Kauai: A longitudinal study from the prenatal to age ten. Honolulu: University Press of Hawaii.

Werner, E.E. & Smith, R.S. (1977). Kauai's children come of age. Honolulu: University Press of Hawaii.

Werner, E.E. and Smith, R.S. (1982). Vulnerable but invincible: A study of resilient children. San Francisco: McGraw Hill.

Wiener, C. (1962). Psychologic correlates of premature birth: A review. Journal of Nervous and Mental Diseases, 134, 129-144.

Winton, P. and Bailey, D. (1988). The family-focused interview: A collaborative mechanism for family assessment and goal-setting. Journal for the Division for Early Childhood, 12, 195-207.

Wise, P., First, L., Lamb, G., Kotelchuck, M., Chen, D., Ewing, A., Hersee, H., Rideout, J. (1988). Infant mortality increase despite high access to tertiary care: An evolving relationship among infant mortality, health care, and socioeconomic change. Pediatrics, 81, 542-548.

Wynne, L.C., McDaniel, S.H. and Weber, T.T. (1987). Professional politics and the concepts of family therapy, family consultation and systems consultation. Family Process, 26, 153-166.

Zeitlin, S. (1985). The coping inventory. Bensenville: Scholastic Testing Service.